Discursive Features of Health Worker-Patient Discourses in Four Western Cape HIV/AIDS Clinics Where English is the Lingua Franca

By

Njweipi-Kongor Diana Benyuei

Dissertation presented for the degree of Doctor of Philosophy (PhD*)*

At

Stellenbosch University

Department of English, Faculty of Arts

Promoter: Dr. Nwabisa Bangeni

Co-promoter: Prof. Christine Anthonissen

December, 2012

Declaration

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signed: Njweipi-Kongor Diana Benyuei Date: December, 2012

Dedication

To the loving memory of my sons:

Kongor Njweipi Keseng Serge and Kongor Ubeendou Gerald

And to all the blessings I still had and those I received after I lost them.

Abstract

This is a qualitative analytical study that investigates the use of English as lingua franca (ELF) between doctors and patients with different L1 at four different HIV/AIDS clinics in the Western Cape. The study addresses a gap in medical research, especially in the field of HIV/AIDS, namely, a lack of sufficient data-driven analytical investigation into the linguistic and conversational nature of doctor-patient communication in ELF in this setting in South Africa. A literature review contextualises ELF, discourse analysis (DA), conversation analysis (CA) and genre theory providing a theoretical framework for the study. The methodology involves audio-recording and transcription of HIV/AIDS consultations conducted in ELF. From the genre perspective, the study investigates the different genres in and determines if HIV/AIDS consultations are a sub-genre of medical discourses. DA investigates what contextual, socio-cultural linguistic features characterise medical interaction in this multilingual context and what ELF linguistic strategies participants use to signal and resolve misunderstanding. CA investigates the turn organisation and turn-taking patterns in the consultations to assess participants' contributions and identify different types of sequences that characterise them, aiming to understand how they enable the interactants play their roles as doctors and patients.

The results reveal that HIV/AIDS consultations exhibit formal features of doctor-patient consultations in general and intertextually revert to other oral genres leading to the conclusion that, considering their purpose, participants and context, HIV/AIDS consultations are like all medical consultations and are a sub-genre of medical discourse. The macro analysis reveals that the interactants' socio-cultural and multi-linguistic backgrounds do positively influence the nature of the interaction in this context as it highlights characteristic linguistic features of ELF usage like borrowing, linguistic transference from L1, the use of analogy, code-switching and local metaphors all resulting from processes of indigenisation and hybridisation. The results reveal few instances of misunderstanding, concurring with earlier studies that problems of miscommunication may be minimal when two languages and/or cultural groups interact. The micro analysis reveals that the turns in the consultation follow the pre-selection and recurrent speakership patterns and that despite the advocacy for partnership between doctors and patients in their contribution and negotiation of outcomes, the doctor unavoidably remains the dominant partner. S/he determines the course of the consultation by initiating more turns, asking most of the questions and often unilaterally deciding on topic changes. S/he has longer talking time than the patient in the sequences and the physical examination and prescription phases of the consultation while the patient is mostly portrayed almost as a docile participant yielding to the doctor's requests and taking very little if any initiative of

his/her own to communicate his/her views and desires. The study reveals instances of both patient and doctor initiated repair to resolve any misunderstanding, which improves the quality of the interaction and its outcomes such as adherence and treatment follow-up. The study further highlights the challenges faced in the field which impacted on the data, the most crucial being the complicated but necessary ethical procedures required to get participants' consent to participate in the study.

Opsomming

Hierdie kwalitatiewe analitiese studie ondersoek die gebruik van Engels as lingua franca (ELF) tussen dokters en pasiënte met verskillende eerstetaal (T1) by vier verskillende MIV/vigs-klinieke in die Wes-Kaap. Die studie werp die soeklig op 'n leemte in mediese navorsing, veral op MIV/vigs-gebied, en bring 'n gebrek aan datagedrewe analitiese ondersoek na die taalkundige en gespreksaard van dokter-pasiënt-kommunikasie in ELF in hierdie omgewing in Suid-Afrika aan die lig. 'n Literatuuroorsig van navorsing kontekstualiseer ELF, genre-teorie, diskoersanalise (DA) en gespreksanalise (GA), en bied 'n teoretiese raamwerk vir die studie. Die navorsingsmetode behels oudio-opnames en transkripsie van MIV/vigs-konsultasies in ELF. Uit die genre-oogpunt bestudeer die navorsing die verskillende genres in MIV-konsultasies, en bepaal of dié konsultasies as 'n subgenre van mediese diskoers beskou kan word. Met behulp van DA stel die studie vas watter kontekstuele, sosiokulturele taaleienskappe mediese interaksie in hierdie veeltalige konteks kenmerk, en watter ELF-taalstrategieë deelnemers gebruik om misverstande aan te dui en op te los. Daarna ondersoek GA die beurtorganisasie en beurtmaakpatrone in die konsultasies, om deelnemers se bydraes te beoordeel en verskillende soorte kenmerkende sekwensies uit te wys, en uiteindelik te begryp hoe dít die onderskeie partye in staat stel om hul rolle as dokters en pasiënte te vervul.

Die bevindinge dui daarop dat MIV-konsultasies formele kenmerke van dokter-pasiënt-konsultasies in die algemeen toon en intertekstueel by ander mondelinge genres aansluit. Dít lei tot die gevolgtrekking dat, gedagtig aan die doel, deelnemers en konteks, MIV-konsultasies soos enige ander mediese konsultasie is en as 'n subgenre van mediese diskoers beskou kan word. Die makro-analise (DA) toon dat die onderskeie gespreksdeelnemers se sosiokulturele en veeltalige agtergronde 'n positiewe uitwerking het op die aard van die wisselwerking in hierdie konteks, aangesien dit kenmerkende taalkundige eienskappe van ELF-gebruik, soos leenwoorde, taaloordrag vanaf die L1, die gebruik van analogie, koderuiling en plaaslike metafore, beklemtoon. Al hierdie eienskappe spruit uit prosesse van verinheemsing en hibridisering. Die studie toon min gevalle van misverstand, wat met die resultate van vorige navorsing ooreenstem, naamlik dat probleme van wankommunikasie minimaal is wanneer twee tale en/of kultuurgroepe met mekaar omgaan. Die mikro-ontleding (GA) dui daarop dat die beurte in die konsultasie die preseleksie- en herhalende sprekerspatrone volg en dat, ondanks die voorspraak vir 'n vennootskap tussen dokters en pasiënte in hul bydraes en bedinging van uitkomste, die dokter onvermydelik die dominante vennoot bly. Hy/sy bepaal die verloop van die konsultasie deur meer beurte aan te voer, die meeste vrae te stel en dikwels eensydig te besluit om die onderwerp te verander. Hy/sy het ook 'n langer spreekbeurt as die pasiënt in die gespreksekwensies sowel as in die fisiese-ondersoek- en voorskriffases van die

konsultasie. Daarenteen word die pasiënt merendeels as ’n bykans gedweë deelnemer uitgebeeld wat aan die dokter se versoeke toegee en weinig of geen eie inisiatief aan die dag lê om sy/haar sienings en behoeftes oor te dra. Die studie toon ook gevalle van sowel pasiënt- as dokteraangevoerde herstel om enige misverstand uit die weg te ruim, wat die gehalte van die wisselwerking én die uitkomste daarvan, soos behandelingsgetrouheid en nasorg, verbeter. Die navorsing beklemtoon voorts die gebiedspesifieke uitdagings wat die data beïnvloed. Die belangrikste hiervan is die ingewikkelde dog nodige etiese prosedures wat vereis word om persone se toestemming tot studiedeelname te verkry.

Acknowledgements

In order to carry out and complete this research I received a lot of assistance, support and encouragement from a number of people and institutions to which I owe a lot of gratitude. In this regard, I acknowledge and express sincere thanks to my promoter Dr. Nwabisa Bangeni for her unrelenting guidance, encouragement and zeal in sharing her knowledge with me during this study. I will forever remain indebted to her especially for the emotional, physical and psychological support she gave my family and me through the difficulties we faced during my study and hope to continue to learn from her humility and diligence. Special thanks also go to my co-promoter Professor Christine Anthonissen for assisting me with regard to ethical clearance as well as for letting me take part in the pilot study she conducted in one of the HIV/AIDS clinics. The lessons I learned and the contacts I made from the experience were very useful when I eventually started this research and for this I am really thankful.

Although this research was mostly self-sponsored since I had no regular bursary, I would never have been able to carry through with it without the financial support I received from the Bursary Fund of the Department of English which covered part of my academic costs. For this, I really want to give sincere thanks to my supervisor, Dr. Nwabisa Bangeni for providing the fancy digital recorder and Dr. Shaun Viljoen (Head of Department) for all the guidance they provided. I particularly thank them for the patience and kindness they exhibited in handling my problems both academic and otherwise, for the troubles they had to go through to make money available to me. In fact beside my husband, they were the ones who occasionally witnessed the emotional and tearful outbursts of my frustrations and so I will never thank them enough.

I deeply appreciate the assistance I received from the management and staff of the Stellenbosch University's Ethics Sub-Committee A for granting me permission to carry out the study, the Western Cape Department of Health for allowing me access to the various clinics in which I collected data and all the doctors, patients and nurses without whom the study would have been impossible. I wish to thank in particular the office of the Superintendent of the HIV/AIDS clinics in the Western Cape, for all the help and support I got from there especially in explaining to the other doctors the purpose of the study. I sincerely thank all the clinic staff for being so welcoming and accommodating considering the tasking nature of their job. Special thanks also go to all the patients who co-operated with the doctors to record their consultations even though they had the choice of refusing to take part in the study. To all of them, I say thank you.

I will forever remain indebted to Dr. Raphael Kongor (my dear husband) who despite his busy schedule with his own studies, found time to drive me to and from my study sites during data collection. I also wish to acknowledge his help in the formatting and fine tuning of the figures and extracts presented in the study. Many thanks to him too for all the financial strain he had to endure supporting our family during this period and not least of all, for being my emotional anchor.

I owe special gratitude to my families back home in Cameroon for constantly praying, encouraging and believing in me. In particular I thank my Mom, Nah Kiria Njweipi for being the 'Best Mother in the world' and for all the love she has constantly shown me in always being there for me and accepting me with all my flaws. I wish to thank my Dad Paa Paul Etabili Njweipi (of blessed memory) for the seed of the yearning for education that he planted in me so many years ago, which has blossomed in the completion of this work. I want to thank all my brothers and their families particularly Mr/s Njweipi Jet, Dr. /Mrs Njweipi Joe, Mr/s. Njweipi Timmy and Mr/s Njweipi Stephen. I equally want to thank all my sisters and their families, especially Mrs/Rev. Umenei, Mr/s Njei Richard. I particularly want to acknowledge my kid sister Mrs Njei Carol Njweipi and one of my nephews, Fon Umenei Emmanuel Njweipi, for believing so much in me that I consider them the driving force behind this lap of my academic career. If anything at all, the completion of this research is to pay tribute to and honour their aspirations for me. I just thank God for putting people like them in my life. I wish to thank my family-in-law and more especially my parents-in-law Paa and Mami Kongor, my sisters-in-law, especially Mrs Tchakounte Eleanor and Mrs Ngi Jane and their families, my brothers-in-law, in particular Mr Ngwang George and Kongor Victor for their prayers, encouragement and moral support. I thank the Cameroonians in the Western Cape and especially the Amumba Cape Town Family Meeting, for being my family away from home.

Above all I thank the Almighty God who has been my inspiration and pillar of strength. I thank him for giving me the knowledge; strength and courage to forge forward even in the midst of difficulties. I could never thank Him enough for the gift of our son Jaden-Ray Etamini Kongor who is a joy to behold and a real reason for me to want to live and give God the glory. Thank you Lord for being so gracious, faithful and loving towards us and for showing us that we can rely on you always.

Table of Contents

List of Figures

List of Extracts

List of Appendices

Abbreviations

AfE	Afrikaans English
AL	Artificial Language
BSAE	Black South African English
CA	Conversation Analysis
CFE	Cape Flats English
DA	Discourse Analysis
EFL	English as a Foreign Language
ELF	English Lingua Franca
ESP	English for Specific Purposes
L1	Fist Language
L2	Second Language
NNS	Non-Native Speaker
NS	Native Speaker
PLwA	People Living with AIDS
SAfEng	South African English

CHAPTER ONE
INTRODUCTION

1.1 Background and rationale

The present study is an investigation into medical discourses focusing on doctor-patient communication where the doctors and patients have different L1s and use English as a lingua franca (ELF) during HIV/AIDS consultations. The study analyses a number of cases where the interaction takes place in intercultural health care facilities, namely in the recently established HIV/AIDS clinics in the Western Cape. My interest is to discover pertinent discursive and linguistic features that characterise such interactions, specifically those where speakers of a variety of different first languages (L1s) are participants, and where patients who mostly have low levels of proficiency in English, have limited knowledge of the illness they are being treated for, and are unfamiliar with the cultural practices in state-funded HIV/AIDS clinics for treatment of a chronic, potentially fatal disease. The study necessarily has to consider the nature of the multilingualism in the community served by the HIV/AIDS clinics, as well as the provisions of the multilingual language policy of South Africa that would govern language choices of speakers and service providers in state health care. The study thus investigates salient aspects of participants' knowledge and use of English as a lingua franca (ELF) as they are manifest in communication in a real life situation. The diverse socio-cultural and linguistic backgrounds of the interlocutors will be considered, as well as their ability to negotiate the interaction from their disparate world views.

The researcher is interested in finding out how misunderstanding may arise, may be recognised (or not), and may be resolved when the interactants use English as a lingua franca in the given context. Recordings made during consultations where interactants are discussing HIV/AIDS symptoms, diagnosis, treatment and the complex issues that comprise the follow-up process will be used as data. Such issues include patient adherence or the lack thereof, the handling of side effects from ARVs, the treatment of opportunistic infections and the overall social, economic, psychological and physical wellbeing of the patient. Although these issues are social in nature, the study explores how they are expressed in linguistic terms during HIV/AIDS consultations in ELF in a unique linguistic environment.

Medical discourse research has recently developed to cover a wide range of areas such as the relationship and communication between participants of different professional and linguistic status. Mostly such research is motivated by concerns for the quality of health care provided when there is

cultural and linguistic discordance between the service providers and the patients (Orr 1996; Ohtaki, Ohtaki & Fetters 2003; Moa 2005; Schouten & Meeuwesen 2006). There is limited work on doctor-patient communication in HIV/AIDS consultation because primary data on doctor-patient interactions, particularly, information on the use of ELF in such a context has not been forthcoming in such a sociolinguistic setting. Increasing prevalence of migration worldwide has assured that numbers of ELF users are increasing and are increasingly linguistically diverse. Besides investigating patterns of language use in clinical contexts such as doctors' consultation rooms, medical laboratories, pharmacies, waiting rooms, and dieting and exercise regimes, research on health communication encompasses health and communication processes in contexts such as conferences, health care reports and reviews about diseases, treatment and death (Wright, Sparks & O'Hair 2008).

Doctor-patient consultations in HIV/AIDS are also represented in the scholarly literature. In exploring the available literature on HIV/AIDS as part of health communication discourse, the researcher found that most centre on aspects such as education regarding transmission, prevention and treatment of those affected and infected by this disease (Dube 2006), on lessons that have been learnt by those who have made contributions to HIV/AIDS research, such as health professionals, policy makers, academics and those who are affected by the pandemic (Ellison, Parker & Campbell 2003) and often have to deal with the stigma associated with HIV/AIDS (Campbell, Nair & Maimane 2006; Campbell, Nair, Maimane et al. 2007). These studies rarely refer to the actual doctor-patient interaction during HIV/AIDS consultations, which in the management of the pandemic, has been identified as of critical importance. The study aims to address this gap, by working with data illuminating some features that mark communication practices in health care consultations between an expert (the doctor) and a lay person (the patient). The following sections will provide background information on the prevalence and public perceptions of HIV/AIDS, and on various research interests in health care communication that are pertinent to the present study.

1.1.1 Studies on HIV/AIDS prevalence

Information on HIV/AIDS has proliferated in the world health scene since HIV/AIDS was first brought to public attention in the early 1980s. Studies such as the one conducted by Singhal and Everett (2003) on communicative strategies used in different parts of the world give staggering statistics of the impact and high death toll of HIV/AIDS particularly in the developing countries where the highest rates of infection are registered. According to this research 95% of the 40 million people living with HIV worldwide in 2002 were in developing countries. The study reported that

22% of adults in South Africa were HIV-positive at the time. Women, children and poor people are most vulnerable to the effects of HIV/AIDS, especially in Africa south of the Sahara (Fiscella, Franks, Clancy & Gold 2000). A gloomier picture is painted in a more recent study conducted by Rohleder, Swartz, Kalichman and Leickness (2009) in which reference is made to the most recent statistics released by the UNAIDS/WHO (2008). This study estimates that 67% of adults living with HIV in the world are in Sub-Saharan Africa and that South Africa has the largest number of people living with HIV in the world. It further identifies Southern Africa as the epicentre of the HIV/AIDS pandemic as it is home to 35% of the total number of people living with HIV in the world. These statistics are of particular interest and motivation to me because, South Africa which is my host country falls in the region that is highly affected by the HIV/AIDS disease.

As a language student I believe that the realities of multilingualism and multiculturalism in the country do in some way impact the way groups of people talk about the infection. In fact, in the case of South Africa, certain words and expressions regularly used in the HIV rhetoric, describe the battle for effective HIV/AIDS treatment in terms probably that are reflective of the context of social strife and background of the affected; for example, phrases such as a 'new struggle' against the illness, 'AIDS denialism' and the description of white blood cells as 'soldiers', resonate with conflict terminology (Colvin & Robins 2009). Some of the negative responses to HIV/AIDS campaigns have been topicalised, as evident in unsympathetic government responses in, for example China and South Africa. Recall the opposition of former President of South Africa, Thabo Mbeki, who delayed the roll-out of anti-retroviral treatment to infected persons, arguing that HIV did not cause AIDS (Singhal & Everett 2003). This put a lot of strain on HIV/AIDS advocacy and unavoidably on the way doctors and patients talked about the disease and possible treatment options (Colvin & Robins 2009).

1.1.2 General themes in public discourses on HIV/AIDS

Public discourse on HIV/AIDS has often focussed on prevention, testing and treatment interventions. Even so, some of the central features of HIV/AIDS discourses in some studies remain stigma and discrimination (see Ackermann 2006). Stigma reduces the efficacy of AIDS programs and quality of life of People Living with AIDS (PLwA) because it inhibits communication and limits participation in prevention programmes, treatment take-up and adherence. People who possess a characteristic defined as socially undesirable acquire a spoiled identity which then leads to social devaluation and discrimination (Deacon, Inez & Prosalendis 2005:15). HIV/AIDS fits this

definition of a stigmatised disease, and the situation of PLwA is worsened by the fact that HIV/AIDS is peculiar in at least two ways:

i. The majority of people infected by it contract the disease through sexual behaviour (and not e.g. blood transfusion or contaminated needles in administering drugs).
ii. There is no known cure for the infection.

Given that in most African societies, sex and sexuality are taboo topics to a larger extent than in less traditional ones, issues relating to them tend to be discussed in very subtle and euphemistic language to avoid embarrassment or being offensive. HIV/AIDS therefore remains a much stigmatised disease, and many who are infected have become stereotyped in HIV/AIDS discourses as promiscuous (Pittam & Gallois 2000).

Other tags that stereotype have been attached to HIV-positive people, such as 'gay', 'black', 'white' 'non-religious', 'young', and 'urban'; such stereotyping allows distancing, so that certain groups are blamed and branded as 'carriers' of the illness (Deacon et al. 2005: 106-107). Some studies indicate that factors such as fear, linking HIV/AIDS to low sexual morality, trigger stigma and limit people's ability to cope and better understand the disease. Such popular perceptions that are manifest in public discourses lead to the violation of basic human rights, such as unfair dismissals, loss of family and friends, and ostracising in the communities (Singhal & Everett 2003; McKee, Bertrand & Antje 2004). These social phenomena have an effect on the nature of doctor -patient interactions during HIV/AIDS consultations since the doctors sometimes have to acknowledge the presence of this type of stigma and discuss the way in which it is expressed and experienced. Besides coping with the illness and awareness of the threat to life, the patients often have to discursively manage social stigma.

1.1.3 General themes in research of HIV/AIDS communication

The existing literature on HIV reveals that research in this field focuses on issues other than the doctor-patient consultation. For example, the Soul City Institute for Health and Development Communication and the Khomanani Campaign of the Department of Health in South Africa propagated HIV/AIDS discourse through their research into the causes, modes of transmission, care and treatment of HIV/AIDS victims focusing on South Africa (Soul City & Khomanani 2004). Some HIV/AIDS research has focused on communicative strategies that are used in different countries for discussing issues of prevention, treatment and adherence (Singhal & Everett 2003; Watermeyer 2008). Others present a synthesis of the critical lessons that have been learned about

effective HIV/AIDS prevention programs (Johnson, Roter, Powe & Cooper 2004; Yeager 2005). These studies cite examples of developing countries like Thailand, Uganda, Tanzania and Brazil (McKee et al. 2004), as well as of developed countries like the United States of America where good communicative strategies such as advocacy for sex education and the use of anti-retroviral treatment, have been developed and implemented (Ohtaki et al. 2003).

Other research has investigated patterns of blame allocation, malevolence, stigma and social distance (Pittam & Gallois 2000; Kalichman, Leichness, Cain et al. 2005; Deacon & Inez 2007). For example, young Australian heterosexual adults were found to blame other social groups to a greater extent than their own group for the spread of HIV (Pittam & Gallois 2000). In the South African context stigma has been identified as one of the factors affecting access to testing, disclosure, treatment, adherence and support (Cameron 2005, 2007; Campbell et al. 2006, 2007). Some medical professionals too stigmatised and discriminated against people living with HIV/AIDS, especially in areas with limited resources. This type of discrimination could impact on the interpersonal communication between doctors and patients during HIV/AIDS consultations.

Other prominent themes in the wider literature refer to the power dynamic manifest in the way information is shared in the interaction between doctors and patients (Brashers, Goldsmith & Hseih 2002). The most vulnerable groups to the infection have been identified in order to facilitate their access to treatment and to design policies that can help them (Deacon & Inez 2007). With the rapidly growing numbers of infected persons the impact of HIV/AIDS on the health system and government departments have been investigated, as well as ways of integrating social sciences with health care in order to provide appropriate care and treatment to HIV/AIDS patients (see Schneiderman, Speers & Silva 2001). Sociologists such as Herdt & Lindenbaum (1992) considered the scope and demography of the HIV infection, while others focused on a better understanding and management of HIV/AIDS and its consequences (McKee et al. 2004). Doctor-patient relationships have been investigated from the perspective of socially and economically marginalised individuals living with HIV (McCoy 2005).

The perspectives given in works cited here indicate that research foci on HIV/AIDS discourse range from blame allocation, malevolence, stigma and social distance (Pittam & Gallois 2000), to identifying and suggesting care of the groups that are most vulnerable to the infection (Fiscella et al. 2000). These studies show that emphasis is laid on education on counselling, prevention and treatment of the infection. The role of language and communication in the various sites where HIV/AIDS is attended to is rarely addressed. This dissertation intends to turn to this lesser

topicalised area, namely to investigate a linguistic aspect of dealing with the illness in a data-driven manner in the South African context. It will investigate how doctors and patients actually navigate the complex topic of HIV/AIDS during consultation in intercultural and multilingual communication.

1.1.4 Research that focuses on groups particularly vulnerable to infection

Recent research has turned attention to how HIV/AIDS affects particular groups of people such as those in the military (Yeager 2005) or in drug-using communities (Latkin, Hua & Davey 2004). Watermeyer and Penn (2009) show how HIV/AIDS discourses take place at the interface of pharmacy and the illness. The present study like her study refers to a small but growing number of patients that for several reasons migrate into the cities and find themselves in consultation with doctors who have a L1 different from theirs. Here, mostly, English is the lingua franca. The importance of good communication is implicit in all these contexts and communities. Considering recent histories of migration related to globalisation, there are growing numbers of people who experience language contact situations where English has become the primary medium of communication across cultural and linguistic barriers, not only in discussing issues of HIV and AIDS. The South African multi-cultural and multilingual environment where the difficult topic of HIV/AIDS and treatment has to be broached is one such area. Health professionals meet people from different cultures and linguistic backgrounds in their line of duty on a daily basis.

1.1.5 Multilingualism and health care, specifically HIV/AIDS-care, in South Africa

Turning to the South African context, Pennycook (1994) and Ellis (2004) have indicated that the peculiar cultural and linguistic environment of the country engenders communicative challenges in public domains. The 1996 Constitution of the Republic of South recognises eleven official languages, providing the possibility for members of the different ethnic groups to use their first language to conduct interpersonal and official business (Mesthrie 2002). Medical consultations between doctors and patients in HIV/AIDS clinics present instances where this provision of service in the client's language choice should be honoured. Unfortunately, the policy does not sufficiently provide for planning linguistic, structural or financial resources to implement such intentions (Anthonissen 2010). Research has shown that not many health workers in South Africa share the same mother tongue with their patients (Penn 2007; Watermeyer 2008; Deumert 2010). Schwartz (2004) reports that as little as 5% of doctors in South Africa are able to conduct interactions in their patient's mother tongue. This puts a lot of strain on those involved in medical interactions as much

research has emphasised that good communication ensures patient satisfaction and brings a shift away from the paternalistic and bio-medical perceptions of consultations that prevailed until quite recently, to ones that view the consultation as a more participative, patient-centred activity (Beisecker 1990; Elwyn, Edwards & Kinnersley 1999). Patient-centeredness requires that the consultation focuses on understanding and attending to the patient's needs and preferences, involving him/her in health care decision-making processes as well as making an effort to understand their world view (see Mead & Bower 2000; Post, Cegala & Miser 2002). This could be a challenge in a multi-linguistic and inter-cultural context such as that in the HIV/AIDS clinics in South Africa where often the participants have disparate world views due to different cultural backgrounds. Some research (Anthonissen & Meyer 2008; Watermeyer 2008), commenting on the issue of language in South African health care communication, assert that language barriers affect a patient's ability to ask questions and understand instructions about medication and ultimately the patient's experience of health care.

Studies in doctor-patient interactions between participants with mutually unintelligible L1s have indicated the risk of inaccurate transfer of crucial information during consultations (Ohtaki et al. 2003; Meyer & Apfelbaum 2010) as well as instances of withholding of information from doctors because of fear and confusion. Watermeyer (2008) refers to such a situation of ineffective communication that exposes some of the challenges associated with the use of interpreters who lack professional qualification such as inaccurate interpretation (Baraldi & Gavioli 2010). Due to the complex relations across language barriers in the South African medical context and in the wider South African society patient disempowerment cannot be viewed only in terms of language barrier. Some research (see Crawford 1999; Ellis 2004) reveals that language in this context is embedded in a system that perpetuates inequality and makes it difficult to develop an integrated order from the traumatised past because the reality is that the doctors and patients are separated by a gulf of social class and often also race and language. The social meaning of the selection of English as the preferred Lingua Franca in the HIV/AIDS clinics has to be considered in connection with such non-linguistic social realities.

1.1.6 Linguistic and communicative features of medical consultations

Research into the nature of linguistic communication in medical practice has identified interpersonal relationships, exchanging information and making treatment related decisions as the three main purposes of communication in medical consultations (Ong, De Haes, Hoos, & Lammes 1995). A medical consultation, at least until recently, was distinguished by its instructive nature and

the definitive power relations that almost always favour the doctor, disempowering the patient (Pendleton & Hasler 1983). In a multilingual society like the South African one where health professionals interact with patients from various backgrounds, establishing such interpersonal relationships through communication can really be a problem as has been mentioned. This is exacerbated when the doctor's style asserts control or when he/she uses medical jargon that lacks explanation and enough information (Buller & Buller 1987, cited in Ong et al. 1995: 906).

Investigations into doctor-patient communications have highlighted the broader linguistic constraints that can be ascribed to the organisational context within which consultations take place (Potter & McKinlay 2005). The institutional context at clinics does represent asymmetry in power in HIV/AIDS consultations as it does in discourse in other institutional contexts such as the classroom and the courtroom. By the very nature of their jobs doctors are expected and supposed to have specialised knowledge of illness and treatment possibilities, thus a certain kind of power imbalance is to be expected. How much time doctors can reasonably spend talking with one patient is part of the communicative challenges. Fairclough (2001: 38-39) points out that "power in discourse is to do with powerful participants controlling and constraining the contributions of the non-powerful participants" because the dominant interlocutor who in this case is the doctor is often the one who sets the tone and controls the course of the conversation. However, it has been found that despite this, doctors are less likely to abuse their power and overlook the patients' requests (Edwards, Staniszewska & Crichton 2004). Although the present study is not focused on exploring the power dynamic in the consultation it would be interesting to see how this aspect plays out in the interaction in terms of how the doctors try to attend to the patients' needs.

It is against the background of the severity of the illness and the vast amount of work that already gives a kaleidoscopic view on the HIV/AIDS discourse, that the present study is undertaken. It aims specifically to address the gap in attention to certain communicative challenges that arise in treating the illness in multilingual communities.

1.2 Problem statement and focus

The present study investigates pertinent linguistic and discursive features of doctor-patient HIV/AIDS consultations in ELF between participants with mutually unintelligible L1s. It intends to find out how interactants in this context signal and resolve misunderstanding bearing in mind that various participants have varying levels of proficiency in the language. Considering that communication is a basic human activity where variables such as age, sex, social class, context and

topic determine the course and structure of linguistic exchanges, the present study seeks to explore HIV/AIDS consultations between doctors and patients in some HIV/AIDS clinics the Western Cape. The study assumes that varying levels of proficiency in English prevail between doctors and patients, and that this would have an effect on the interaction at the lexical, syntactic and discursive levels, thus revealing the linguistic and ELF features that are the focus of the study.

1.3 Research questions, hypotheses and objectives

The study is carried out and the data analysed with the following research questions, hypotheses and objectives in mind.

1.3.1 Research Questions

The questions to be addressed in this research are:

i. What linguistic and discursive features characterise HIV/AIDS consultations in clinics where English is used as lingua franca?
ii. Which discursive strategies used in medical consultations in this setting where English is used as a Lingua Franca, signify (i) different levels of proficiency in English, (ii) different levels of familiarity with the communicative context, and (iii) awareness of the communicative fragility of the particular encounter?
iii. Is there evidence of widespread misunderstanding among participants: what markers of misunderstanding are recognised, and how do participants respond to and resolve misunderstandings that do occur?
iv. Which linguistic and discursive features identified as typical of HIV/AIDS consultations in this setting can be characterised as ELF features?

1.3.2 Hypotheses

The research hypotheses are:

i. The form and content of consultations conducted between doctors and patients in HIV/AIDS clinics have a relatively similar generic structure that is determined by the aims of the consultation. These are likely to be comparable to those in clinics treating other chronic medical conditions such as hypertension and diabetes. However, there are likely to be a number of linguistic and discursive features in HIV/AIDS consultations where English is the medium of communication, that are peculiar to ELF usage in other institutional discourses.

ii. In medical consultation through medium of ELF, patients are likely to have lower levels of English proficiency than the doctors, due possibly to differences in level of education and socio-economic class. Such differences will determine that the doctors have greater control of the interaction and will talk more, while patients will be prone to longer silences and shorter conversational turns. Doctors will be more knowledgeable in health matters and more familiar with the communicative context. Even so their conversational contributions are likely to show awareness of the sensitivity of the consultation as a communicative event. Patients' contributions will most likely also carry markers of insecurity and fragility.

iii. With differing levels of English proficiency and differing kinds of knowledge of the context, it is hypothesised that there will be a greater likelihood of misunderstanding than in other ELF encounters. Regular patterns of resolving misunderstanding, such as rephrasing and asking questions are expected to occur.

iv. ELF in this context fulfils communicative functions that are comparable to the general functions of any lingua franca, namely facilitating communication between people who would otherwise not be able to communicate because they do not share a common language. Thus it is hypothesised that these consultations will be marked by the use of communicative strategies that regularly occur in ELF communication, such as the negotiation of meaning, repetition and elaboration.

1.3.3 Objectives

The study will focus on the use of ELF in a multilingual situation and how it affects the transmission of information during HIV/AIDS doctor-patient consultations. Bearing in mind the complexity of the use of ELF under such circumstances, the research, therefore, aims to:

i. Record and analyse features and strategies used by participants in the consultations, such as the negotiation of meaning and the organisational structure of the consultation.

ii. Investigate how misunderstanding is recognised and how it is resolved in ELF, particularly where participants have varied levels of proficiency in English.

1.4 Theoretical points of departure

The present study conceptualises ELF in this context as a language used for special purposes between interactants who do not share a common L1. This places the study within the framework of world Englishes in that it reflects some peculiarities of the varieties of English used in South Africa. The study focuses on HIV/AIDS consultations from a linguistic perspective carried out within the

framework of approaches in pragmatics since making meaning is a dynamic process, involving the negotiation of language between speaker and hearer, and the context of utterance (Boxer 2002). In particular the study employs descriptive and analytical tools from the theoretical domains of conversation analysis (CA) and discourse analysis (DA) respectively. It explores doctor-patient HIV/AIDS consultation as an interpersonal activity between the participants.

Discourse analysis is an analytic approach that seeks to find the linguistic and contextual devices used by speakers in making the discourse coherent. It draws on frameworks established in other disciplines such as anthropology, sociology, philosophy and linguistics, all research fields that are relevant to medical discourse (Paltridge 2006) and doctor-patient interactions in particular. The study is informed by ideas developed in CA from as early as 1972. It works with tape-recorded data and takes a particular interest in how speakers manage turns, and make their contributions salient in spoken interaction. CA works on the premise that social actors do not just follow externally imposed rules of interaction but that they are always actively creating order through their own behaviour (Ochs, Schegloff & Thompson 1996). CA bases its analysis on the description of the sequential organisation of talk and has been widely used in the analysis of medical discourses (Heath 1992; Ten Have 1995). CA is relevant to the present study as a tool for describing the data that consist of recordings of real life consultations. The study further considers the concept and definition of genres as they reflect the versatility and dynamism of linguistic categorisation and allow interlocutors to benefit from their situations in view of their communication goals (Halmari & Virtanen 2005: 10). From this perspective, the study identifies and discusses the different types of communicative genres that constitute the HIV/AIDS consultation as a sub-genre of medical discourses. Finally, the study will get inspiration from recent works on the use of English as a lingua franca in other multilingual spoken encounters such as classroom interaction and learning in higher education context. The analyses will consider which of the features typically found in these consultations are markers of medical consultation generally, markers of HIV/AIDS consultation specifically and to what extent these characteristics may be determined or co-determined by the fact that the medium of communication is the L1 of none of the participants, but is specifically ELF

1.5 Research design and methods

The present study employs qualitative analytical methods that comment on the nature of the interaction during consultations at four HIV/AIDS clinics in the Western Cape in South Africa. From this perspective the study allows the researcher to make deductions about language use as evident in the data collected regardless of the frequency of occurrence of the phenomenon that is

being investigated. Thus it does not follow a quantitative method that depends on a large amount of representative data where facts and conclusions are determined by numbers of subjects or frequency of occurrence of the phenomenon being investigated. Since this research is not interested in knowing if the consultations presented in the study are an accurate reflection of HIV/AIDS consultations broadly, and does therefore not expect the findings to have any generalisability, a limited number of consultations will be sufficient for this qualitative analyses (see Mouton 2003).

Although there has been controversy on the integration of these seemingly contradictory approaches in the study of medical dialogue; it is believed that such an approach has the potential to lead to a rich and meaningful study of interaction in general (Heritage & Maynard 2006). Despite the strength of accuracy of quantitative approaches and methods, the present study has used the qualitative approach because of its ability to provide detailed answers and micro-level insights in which the research is interested. Commenting on the kind of data derived through audio-recording (verbatim transcripts of various consultations involving different participants at different times without any particular importance being attached to the numerical and statistical value of the observations) will be done in such a way as to provide pointers to what may eventually turn out to be typical of the given genre. The merits and shortcomings of this approach and method are discussed in further detail in Chapter 4.

Thus, this research is designed qualitatively, working with a collection of cases where doctors see HIV-positive patients in consultation when they visit state-provided HIV/AIDS clinics for diagnosis, advice and treatment. It is designed to gain insight into how the oral communication between the service provider and client is managed when the two interlocutors do not share a common first language. The data used in the study consist of 19 HIV/AIDS consultations that were tape-recorded within a period of eight weeks. These consultations involved four doctors and 19 HIV-positive adult patients who consented to being participants in the study. The only inclusion criteria used for selecting participants during data collection were age and language. The participants were all adults (older than 18) who did not use their L1, but reverted to English (ELF) as a medium of communication during consultation. These variables are elaborately discussed in Chapter 4. In the analysis of the recorded discourses, a multi-method approach is taken, drawing on analytic procedures provided in the fields of CA, DA, genre theory and English as a Lingua Franca.

1.6 Structure of chapters

Chapter One: This chapter presents the background and rationale to the study. It presents some information relevant to medical discourse and identifies the need for research in the field of HIV/AIDS. The chapter highlights the challenges faced by health care practitioners in inter-cultural contexts with particular interest in the use of ELF in the HIV/AIDS clinics in South Africa. The researcher notes that despite the preponderance of literature on issues of HIV/AIDS, there is a limited amount of linguistic analysis of doctor-patient interactions in this field in the South African context. The chapter presents the problem statement, the particular questions that the research seeks to answer, some hypotheses and objectives and briefly mentions the different theoretical approaches that inform the study. Chapter one identifies the research design and methodology of the study.

Chapter Two: This chapter elaborately discusses the origins and definition of lingua francas and the circumstances that engender their development as well as the roles they play. It highlights the fact that lingua francas can emerge from mutually unintelligible languages coming into contact in the form of pidgin and Creole languages, but that in bilingual and multilingual communities a shared second language with wide representation (such as English, French or Spanish) can function as lingua franca. Although they are typically used for cross-cultural communication in the workplace, in trade and in diplomacy, the roles of lingua francas and the contexts in which they function have broadened as seen in the example of ELF. The literature review discusses the development and spread of ELF in Africa and other parts of the world, noting the fact that the language develops context-specific characteristics in interaction with regional languages and socio-cultural and geographic aspects of the context. Particularly, the role of ELF in the intersection between inter-cultural communication and medical discourses is emphasised with a keen interest in the South African context. Some of the literature debunks the general belief that lingua franca communications are ridden with misunderstanding. The chapter highlights the absence and need of research that attends to the use of ELF in everyday communication, as well as in consultations among individuals who do not share a common L1 in South Africa. It indicates that so far, limited research has been done on the use of ELF in the medical setting, especially in the field of HIV/AIDS in this context where participants use their limited proficiencies to communicate and resolve misunderstanding.

Chapter Three: This chapter highlights the congested nature of the definition and scope of the concept of ‘Discourse’ as it is presented by different scholars, especially in Applied Linguistics and among post-structuralists whose perceptions of the term are relevant in this study. The chapter

discusses the theoretical frameworks that have been used to study language use. It begins with a CA, DA and the strengths and limitations of both approaches as well as exploring the different linguistic features to which they pay attention. Considering consultation as a sub-genre of medical discourse, I discuss genre theory and highlight the difficulty often confronted by researchers in delimiting different genres. The chapter further refers to studies on HIV/AIDS discourses noting the paucity in research into the nature of communication between doctors and patients especially in HIV/AIDS consultations in ELF situations in South Africa. I proceed to discuss some of the approaches used by researchers in the study of doctor-patient interactions, highlighting the paradigm shift from their biomedical and paternalistic perceptions of the consultation presented in earlier research as opposed to the patient-centred and partnership models that have been advocated in the last two decades.

Chapter Four: This chapter gives an exposition of the research design and method used in the study. It explains why a qualitative approach is suitable for the study. In this chapter I identify the specific method used in the present study, describing in detail how it is used to get the data required to answer the research questions I set out with. The method used is mainly audio-recording of the consultations. I discuss the research participants and how selection was done. The chapter ends with an explanation of the procedure to get ethical clearance and authorisation, which was important considering the particularly sensitive context in which data was collected as well as the vulnerability of the patient-participants.

Chapter Five: This chapter introduces the ways in which the various theories are invoked in the data analysis and proceeds to actually give the analyses. First I present an analysis from the CA perspective, indicating how participants manage turns in the consultation. The different turn-taking techniques and the rules of selecting or assigning a speaker's turn in this context are investigated and made apparent here. Second I analyse the discursive structure, trying to identify the features that contribute to coherence and appear to be markers of the consultation as genre. Referring to the CA notion of 'repair', I pay specific attention to possible occurrences of misunderstanding, identifying strategies that are used when there is some threat to the coherence of the discourse. Various ways in which either of the participants signal awareness of breakdown and try to repair the conversations, will be highlighted. From the DA perspective, the impact of socio-cultural aspects of the context of the consultation is taken into account. Here ELF features are identified in that lexical, syntactic and discursive features that mark the communication as an L2-interaction are attended to. Generally features of ELF are investigated for their contribution to the coherence they may bring

and so contribute to communicative success in the consultation. Finally, I discuss the different conversational genres that are reflected in the consultation.

Chapter Six: This chapter is the general conclusion of the study. It summarises the key findings and the impact of the study. It highlights the shortcomings and the challenges encountered in carrying out the study and proposes recommendations for further research.

CHAPTER TWO
CONTEXTUALISATION OF LINGUA FRANCAS AND THEORETICAL FRAMING OF ELF IN MEDICAL CONTEXTS

2.1 Introduction

This chapter presents a literature review that documents the characteristics and use of lingua francas highlighting their function in inter/cross cultural communication. Where relevant, work highlighting the uses of a lingua franca in the medical context will be presented. It provides a conceptual framework for considering the use of ELF in the study and discusses the expanding role of English as a medium of communication worldwide but particularly as a common language used by people from different socio-cultural and linguistic backgrounds interacting in a medical context. The literature review indicates recent changes in the research foci of scholars interested in English used as a lingua franca and points to the link between lingua francas and medical discourses. Seminal contributions to lingua franca research are also discussed. This chapter further discusses how misunderstanding is managed when speakers communicate using a lingua franca and especially ELF interactions. The chapter also discusses ELF as a linguistic and cross-cultural phenomenon, with particular interest in its use in the cross-cultural medical contexts especially in South Africa. The chapter discusses the different linguistic repertoires that are available to the people living in the Western Cape. This will provide the basis to investigate how patients and health care givers with different L1s navigate the challenge of communicating to each other in ELF given the language policy in the province, which recognises Afrikaans, Xhosa and English as official languages.

2. 2. The characteristics of lingua francas

Languages have functioned as lingua francas from when people started to migrate beyond the boundaries of the areas they originally inhabited (Meierkord 2006a). The sociolinguistic situation of any language includes the general socio-cultural conditions in which the language finds itself and develops at a particular time (František 2000). He observes that, "human languages are in a turbulent state of flux, due to the migration of people within individual societies, states and continents, resulting in extensive contacts between people, their groups and cultures, which allow a language to acquire new dimensions and character as well as a certain degree of instability, uncertainty and variability in the structure" (František 2000: 10). Lingua franca communication is thus understood to develop from language contact in a linguistic situation which is characterised by co-existing and competing linguistic features of different languages, levelling of differences and

mixing of the languages, resulting in instability and variation and peculiarities especially in their structures (Thomason 2001; Meierkord 2004; Canagarajah 2006).

The characteristics of lingua francas are revealed in the various definitions of the term lingua franca and relate to its functions and the way it is conceptualised in a given context. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) in 1953 defined a lingua franca as "a language which is used habitually by people whose mother tongues are different, in order to facilitate communication between them" (Barotchi 1998: 505). Thomason (2001) shares this view because he believes that areas where lingua francas are in regular use are multilingual more or less by definition. In such contexts, lingua francas operate as auxiliary languages that facilitate communication between people with mutually unintelligible languages within and across countries and function as languages for trade, the spread of the gospel and colonisation. Considered from this perspective, a lingua franca is perceived as a contact language which is often spoken only as second language or one that is used for wider communication usually in cross-cultural communication and is variously referred to as a common language, an auxiliary language (Barotchi 1998) or a "language of wider communication" (Meierkord 2006a: 163). The following are examples of established formal languages which function as lingua francas and have been adopted for various reasons by users other than their native speakers. Latin was adopted as lingua franca as the Roman Empire expanded into Italy and other linguistically diverse areas such as Gaul, Iberia and North Africa, which resulted in mixed languages, transliteration and phonetic interferences (Adams 2003). Without replacing the indigenous languages spoken in the conquered territories, Greek became the lingua franca of commerce, the military, administration and taxation in the Macedonian empire (Bubenik 1989). Standard Czech functions as a lingua franca and is influenced by the specific Czech diglossia, the continuous process of functional differentiation between national and official languages and the massive impact of foreign languages, especially English (František 1997). Other examples of established formal languages which function as lingua francas are French, spoken in Sub-Saharan west Africa, Arabic, spoken in more than 20 countries in the Middle East and Africa and English which has been classified as a "global lingua franca" (Meierkord 2006a: 165).

The term lingua franca also refers to any language widely used beyond the population of its native speakers or a language that is used as an international auxiliary language between speakers of different native tongues. Lingua franca has been described as a vehicular language because it goes beyond the boundaries of its original vernacular community and develops localised forms. Meierkord points out that, "lingua francas are used as second or third language for communication and signalling of identity by users of different cultural backgrounds" (Meierkord 2006a: 22). Such

users often face the challenge of "retaining (their) indigenous cultures and language(s) while reaping the benefits of large-scale integration via a language of wider communication" (Modiano 2004, cited in Canagarajah 2006: 225). Considered from this perspective, lingua francas are complementary to the other languages because in many such situations there is role differentiation and it is the interlocutors who decide what language suits their purpose. This is characteristic in situations where lingua francas are initiated by the spread of languages of power and prestige through conquest and colonisation (Mesthrie 2002; Meierkord 2006b). For example, English is a vernacular in England, but it is used as a vehicular language in many other parts of the world.

Lingua franca sometimes refers to the *de facto* language within a more or less specialised field, such as the military, international radio communications or medicine. This is the case with planned languages which have been specially invented possibly because of the need to communicate in a specific code and the need for a neutral language to facilitate international communication. Some have been referred to as artificial languages (AL) even though to some extent they too can be considered as natural languages since they have become the mother tongue of some children. An example of this type of lingua franca is the Esperanto that was invented by Ludwig Lazarus Zamenhof (Forster 1982: 356). Esperanto was used as an international language for peace and international understanding from about 1887 and is still used by some people in Europe today as a L1. This indicates that from a functional perspective any language can become a lingua franca.

Lingua francas are used for different purposes in different contexts and situations and so they have been classified accordingly. For example, Samarin (1987) divided lingua francas into natural, pidginised, creolised and planned languages. The lines between these are sometimes blurred. For instance although all pidgins are lingua francas not all lingua francas are pidgins. Crystal (1997) concurs with this view as he observes that pidgins are auxiliary languages in their nature since they are learned alongside vernacular languages. The appellation lingua franca therefore covers both artificial and natural languages as well as creoles and pidgins (Barotchi 1998). Pidgins have been reported to be limited in function and are usually only used in specific domains and settings (Strevens 1984; Lesznyák 2002). A pidgin is often described as a 'make-shift', 'marginal' or 'mixed' language which although not a native language to anyone, is used among people who do not share a common language but who want to talk to each other for trading or other reasons (Crystal 1997: 334). Examples of widely used pidgins are Krio in Sierra Leone and Nigerian Pidgin English. A Creole on the other hand is a pidgin language that has become a mother tongue of a community. So, unlike the pidgin, the Creole is a vernacular language in its own right. Examples of these are the Creoles of the Caribbean (Crystal 1997).

Some lingua francas are classified as intra-national, intraregional or international. This is because even though they are very instrumental in international communication and diplomacy among states they also function as a common language within some multilingual states. Diplomacy is one of the areas of cultural exchange that entails conducting negotiations between representatives of groups or states and usually involves the intercession of professional diplomats in the negotiation of international relations with regard to issues of peace-making, trade, war, economics, information technology, science and culture. The necessity for a common language that can cut across these barriers is obvious. Examples of these are Arabic, French, Spanish, Russian and English used in particular geographic regions (Brown, Anderson, Bauer, et al. 2006). Russian for example was instituted as the dominant language to linguistically unify the Soviet Union in the larger part of the twentieth century (House 2003), while Arabic is spoken in the Arab countries of the Middle East and North Africa (Meierkord 2006a). English is currently used as an international language, an official language as well as language of international trade and technology in many countries of the world such as Cameroon and Nigeria (Bamgbose & Banjo 1995) and South Africa (De Klerk 1996), as examples from the African continent. However, in the South African case, Afrikaans had been a lingua franca among the speakers of many different languages such as the Khoekhoe, the Germanic dialects, French and the many other languages spoken by the slaves (McClean & McCormick 1996; McCormick 2006). McCormick (2006) discusses and highlights the hybridisation of acrolectal, pidgin and learner varieties of Dutch which resulted in the development of Afrikaans as a lingua franca in the political landscape of South Africa especially its use mainly in and around Cape Town. But the main focus of this research is the use of English as a South African lingua franca and the prominence it has gained over Afrikaans.

The circumstances that define lingua francas are varied even though they share the common characteristic of functioning as a medium for facilitating interaction between speakers in multilingual communities and being a common language to people who do not share a L1. But the functions of lingua francas have expanded as they are also as media of instruction in academic settings (Mauranen 2003; Verhoef & Smit 2003; Smit 2005; Jenkins 2002, 2006) and serving as a unifying factor and language of diplomacy (Foley 2006). The characteristics that have remained constant about lingua francas though are their ability to bring a dimension of neutrality as a medium of communication and their function as a common language in a multilingual context.

2.2.1 Recent interests and trends in lingua franca research

The various theories and methodologies used in lingua franca research attest to the diverse interests of researchers and the changing trends in ELF research. Empirical studies with an interest in ELF have used theoretical approaches as varied as CA, DA and ethnography. For example, Watermeyer and Penn (2009) combine CA and DA approaches to yield a complementary analysis of data in an investigation of pharmacist-patient interactions in ELF in an HIV/AIDS clinic. Other qualitative methods such as interviews, case studies, tape and video recordings and questionnaires have also been used. Levin (2006) uses semi-structured interviews to investigate how the differences in cultural and linguistic background of English or Afrikaans health care providers and Xhosa patients influence their definitions of common medical terminology. In a case study, Schlemmer and Mash (2006) explore the effects of language barrier on health workers and patients in a district hospital in Cape Town. Watermeyer (2008) uses audio recordings to explore the organisation of pharmacist-patient interactions in HIV/AIDS clinics where English is a lingua franca, while Deumert (2010) employs questionnaires, interviews and ethnographic observation to investigate the role of multilingualism in health care focusing on the linguistic barriers between Xhosa patients and English/Afrikaans providers in the public health system in the Western Cape.

It is evident from existing literature that trends in research in English as well as ELF are constantly changing. Early studies on lingua francas were mostly descriptive and documented instances of language contact and the social and linguistic processes that characterised the communicative situations. Kachru (1992: 356) for example, discusses the issues around indigenisation and hybridisation and describes the socio-historical development and diversity of English worldwide as it came into contact with indigenous languages in the British colonies and proposes models for teaching non-native Englishes based on three circles (also see Kachru 1983, 1986). He classifies the spread of English under the ‘Inner Circle’ (which claimed ownership and the establishment of norms), the ‘Outer Circle’ (where English was a second language, with well established local norms since colonial times) and the ‘Expanding Circle’ (where English was used as a foreign language) (Kachru 1992: 356). This model recognises the native speaker’s performance (the inner circle) as the ideal to which the non-native speakers (the speakers of the outer and expanding circles) must aspire. It is also suggested in some research that ‘Nuclear English’ which is a form of English characterised by a reduction of complex relative clauses and modal verbs be used to facilitate teaching to and learning for the non-native speakers (Meierkord 2006b). Some research shows that the negotiation of meaning between non-native speakers of English with different linguistic backgrounds reveals problematic issues of linguistic interference (Varonis & Gass 1985; Schwartz

1980, cited in Meierkord 2006a:168). However, the ELF users in this research do not have any native speaker ideals to which they aspire and so they are considered as language users in their own right.

The focus of lingua franca research later shifted in the late ’90s from the language contact scenario and broadened to include documenting the forms and functions of the lingua francas and the different varieties that are used in different situations and regions of the world. This period saw the growth and acceptance of English as a global lingua franca with regional varieties. The hegemony of English as a global language is focal to research which indicates that the reasons for its spread are linked to the role it plays as language of international communication, information technology, commerce, diplomacy, politics and sports (Gill 1999; Crystal 1997, 2003). They emphasise the uniqueness of regional varieties of English. While acknowledging the different varieties of English as seen in Kachru (1983, 1990), some researchers (e.g. Meierkord 2004, 2006a) still uphold the performance of the native speaker (NS) in certain contexts as the ideal towards which the non-native speaker (NNS) has to aspire. Failure to excel in this regard could have negative consequences for the individual.

Other trends that have developed in ELF research have investigated its use in business contexts (see Pitzl 2005) as well as illustrated its role in academic contexts. Research that focuses on ELF in academic settings highlights the fact that the academic interactions are different from casual conversation or dyadic speech like the doctor-patient consultation because the role it plays here is more regulated (Mauranen 2003; Verheof & Smit 2003; Jenkins 2002, 2006; Smit 2010). Such interactions show that despite the differences in the ELF varieties, speakers do manage to perform demanding communicative tasks through negotiating meanings, arguments and alternative viewpoints and also carrying out the kinds of discourses which constitute the institutional settings they are in.

Some ELF research has focused on investigating how ELF users manage to retain their cultural and linguistic identities while using a language that is not originally theirs (Pölzl & Seidlhofer 2006). They investigate how ELF interactants make the language their own and use it to retain and signal their identity. Interactants in lingua franca communication either consciously or unconsciously “negotiate the trade-off between achieving a satisfactory degree of mutual intelligibility while retaining a comfortable measure of personal identity” (Pölzl & Seidlhofer 2006: 152) or as House puts it they “remain true to their own personalities” (House 2002: 262).

With time the role of ELF changed because of the way English was nativised in postcolonial communities (Bhatt 2005; Kachru 1986) and moved beyond the earlier models of global English. Scholars now generally agree that the World English (WE) model fails to accommodate the complexity of global English (Canagarajah 2006). He points out that the exonormative conceptualisations of ELF and NNS interactions as inadequate and sub-standard have been challenged. These conceptualisations are based on the foreign perception that NS performance is the ideal to which NNSs like ELF interactants should aspire. The relationships and assumptions about English have been altered due to globalisation with the result that scholars have been moving to models of global English that portray the relationship between communities in more fluid and egalitarian terms. Many are therefore adopting the position that English is a heterogeneous language with multiple norms and diverse systems (Canagarajah 2006). This is evident in the assertiveness and confidence of NNSs in the use of their regional varieties. This shows a new trend in lingua franca usage, one in which the NNS neither needs to seek the approval of the NS for any variations in their English, nor aspire to the NS's level of proficiency. Even in teaching, Seidlhofer (2001, 2005) and Jenkins (2006) propose an alternative model for the teaching of English as lingua franca which is expected to impact on pedagogy and teacher education. This model recognises the autonomy of regional varieties of English and how they vary in terms of form and function.

More recently from around the late 1990s to date, there has been a proliferation of research into lingua franca communication not just focusing on the recognition of regional varieties of English, their different characteristic features and functions, as well as identifying their specific socio-cultural peculiarities and autonomy but also its function and form in different settings. Researchers (e.g. De Klerk 1996; Seidlhofer 2000; Verhoef & Smit 2003; Meierkord 2002, 2006b; Foley 2006; Dewey 2007a, 2007b) have accumulated a body of evidence to argue that the different varieties of ELF be treated as languages in their own right, used by different people for different purposes and reasons. This trend counteracts the reproduction of native English dominance. In conclusion one can safely say that lingua franca research in general and research on English and ELF in particular have seen a gradual but sure shift in research focus from lingua francas merely being seen as contact languages and inept imitations of other target languages, to the conceptualisation and investigation into the forms and functions of ELF and regional varieties as distinct varieties of the English language in their own right. The following section discusses the different ways in which ELF has been conceptualised in some studies and indicates how relevant these are to the understanding of ELF in the present study.

2.3 The conceptualisation of ELF in the study

Scholars have conceptualised ELF in different ways in various contexts depending very much on the functions it performs and its variety. As discussed below, some research has conceptualised ELF in terms of its function as a language for communication as opposed to a language of identification in the case of a mother tongue or first language (L1). For instance, as a language for communication, it is "…a useful instrument for making oneself understood in international encounters" (House 2003: 559) and inter-cultural interactions because it enables communication between people who do not speak the same L1. The present study follows this particular position because ELF in the HIV/AIDS clinic is used as a language for communication by interactants with mutually, unintelligible L1s for their own communicative purposes that are not primarily identity expressions. This indicates that the language is used in this particular context for a particular reason and purpose by the people involved. Although some studies (House 2003) point out that ELF is neither a national language nor a language used for marking identity, I believe that the variety of ELF spoken in certain contexts does give an indication of the cultural and linguistic identity of the interactants. In countries where English was first an international language and then became a second language before being recognised as a national language, it is difficult to differentiate it from ELF. This conviction is built on the premise that ELF users may have different cultures, and language is the means by which certain aspects of culture are signalled to others and passed on from one generation to the other (Canagarajah 2006). So to some extent a variety of ELF can be used as a language to mark the identity of its users and this is what I am hoping my data will reveal (see *Chapter 5, section 5.3.2*).

ELF has been described as a hybrid language by House (2003: 573). This view is strengthened by the fact that with the spread of English to many parts of the world, it has functioned as a contact language of trade or power emanating from a colonial past, and that it is a L2 or national language to many NNSs (Kachru 1990; Meierkord 2006a, 2006b). ELF interactions always develop in situations where people migrate across ethnic, regional and national boundaries because of globalisation. As a result, English in its role as lingua franca has been conceptualised both as a common language because of the large number of its NNSs and as a neutral language because it is free of ethnic sentiment as will be discussed later. ELF is a type of English and although it is not a contact language in the way in which some regional varieties of English originally were in the past, the residual effect of contact between local indigenous languages and English is still evident in different ELF varieties in terms of vocabulary, syntax and discourse forms. For this reason, the line

between ELF and English L2 in these contexts is not clear cut. Consequently, ELF and English is sometimes used interchangeably in some contexts e.g. in Africa.

The idea of identifying the varieties of English spoken by the interactants is not as important in the present study as the fact that they are speaking in English since this is the only shared language they have. This is the reason they are referred to as ELF users since what sets them apart is the fact that they are not NS of English nor L1 users of the language ELF, nor do they "…desire to become similar to valued members" of this group (House 2003: 560). Even in terms of formal description there is an indication that "ELF talk cannot be conceived with a view to an ideal English norm and the ELF speaker cannot be measured in his/her competence vis-à-vis the native speaker because the language keeps changing" (House 2003: 557). But some researchers have suggested that ELF be taught as a language in its own right in particular contexts. This has been done in the case of English for specific purposes (ESP) to inspire the development of autonomous language capabilities which draws on "mediated corpus-based genre analysis for ESP teaching" (Hüttner, Smit & Mehlmauer-Larcher 2009: 108). Teaching and learning ESP refers to developing a vocabulary and grammatical forms that will enable communication in dedicated areas, such as trade or marketing which are different contexts of ELF use by extension. These different views indicate a controversy with regard to how ELF ought to be conceptualised. It is important to mention that even though the scope of ELF use in the South African context is widening ELF as a variety has not made such strides in pedagogy. So, the ELF speakers in the HIV/AIDS clinics have not had any specific education on how to use ELF in the medical context. Nevertheless when they do use English sometimes as the only communicative instrument as it is the case in this study, it illustrates an instance of ELF as a variety of English amongst World Englishes but emphasises it as language function.

The present study adopts the stance inspired by the proposed ELF research paradigm of adopting a social (macro) view of ELF in the concept of community of practice and taking hybridity as a linguistic and cultural norm (House 2003: 573). Wenger characterised the sociolinguistic concept community of practice in terms of mutual engagement, a joint negotiated enterprise and a shared repertoire of negotiable resources (Wenger 1998: 76). It is contrary to that of the 'speech community' proposed earlier by Fishman and supported by Hymes (1972: 53) which defines a speech community as, "one, all of whose members share at least one single speech variety and the norms for its appropriate use" (Fishman 1971: 232). Their interpretation of the speech community is based on the notion of a speech community being identified on the basis of variation of use and regularity of judgement in the use of some key linguistic features (Labov 1972: 120) with the

understanding that speakers in a speech community have shared beliefs about their language and that of out groups. These conceptualisations do not reflect the nature of ELF interactions and are therefore inappropriate for characterising ELF interactions in the present study. Characteristically, in ELF communication each participant navigates in and out of different contexts in different ways. This implies variation in use, but there is no regularity of judgement in terms of the appropriate use of linguistic features and rules and so there is no single defined ELF speech community. Evidently, there is no expert ELF user and there is no elite speaker group to which participants aspire in the situation under investigation because there is no common point of reference in terms of lexis, syntax and communication strategies used by the different interactants. This conceptualisation of ELF as a form of language used in a particular community of practice is better suited for the understanding and description of the ELF interactions in the HIV/AIDS consultations captured in the present study. It shows the interactants in collaborative meaning negotiations in a joint and negotiated manner, conscious of their limited competencies (House 2003) Consequently, the conceptualisations of ELF as a language of communication, a hybrid language, a common and neutral language, are descriptions which resonate with the concept of community of practice which describes the interactions in the HIV/AIDS consultations in the present study and will give readers a better understanding of the data. Thus, ELF is perceived in here as a language that has developed from heterogeneous sources due to the different linguistic backgrounds of the participants and as a communication tool through which users benefit from the linguistic reserves of regional varieties of English in inter/cross cultural communication to negotiate meaning in their different situations despite their varied proficiencies in English. In the next section, I discuss the reasons for the development of ELF and give some examples of the impact of the socio-cultural context on the linguistic form and content of ELF in some regional varieties of English in its role as ELF.

2.4 Development of ELF and the identification of some regional varieties of English

Due to globalisation English is at the centre of language and communication in the economic, political and cultural life of more people than ever before (Graddol 1997: 3). This explains why English is seen as the current lingua franca of international business, science, technology and aviation and has displaced French as the lingua franca of diplomacy. Some studies show that the English-speaking countries (e.g. the United States and the United Kingdom, Canada and Australia) and the developed Western nations have been very instrumental in assigning English the status of global lingua franca because of their economic hegemony in world financial and business institutions (Crystal 2003; Lesznyák 2004). The *de facto* status of English as the lingua franca in these countries has been carried over globally as a result of their influence. English was and still is a

lingua franca of the former British Empire (India, Nigeria, South Africa and so on), the present British territories (like Bermuda, St. Helena), former British territories (like Hong Kong) as well as U.S. territories (like Northern Marianas, Puerto Rico, the Philippines) to name a few (Kachru 1997). However, the establishment of English as an international lingua franca has mostly been attributed to the spread of cultural and technological exports from the United States (Graddol 1997; Crystal 2003; Dewey 2007a). This status has been strengthened by the fact that out of the six official languages of the United Nations and its organs, that is, English, French German, Chinese, Portuguese, and Italian, English functions as the working language in practice and confronted with the problems caused by the European Union (EU) language policy that gives equal status to the languages of all member states, English has become the EU's lingua franca (De Swaan 2001: 174)
There have been claims that there are more speakers of English as foreign language today than the sum total of those who speak it as L1 or L2 (Graddol 1997: 13; House 2002: 246), and an estimation of up to a billion of people use English as foreign language (Crystal 2003: 61). This view has been supported in a study that has categorised these NNSs into two groups both of which use ELF: those that speak English as a Foreign Language (EFL) and learn it as a medium of international communication and those that speak English as a Second Language (L2) (Trudgill & Hannah 2002: 99-101). In the second group English is either used by NNSs as an official language, and/or language of instruction, and /or means of wider communication within the country. This usually results in a case of diglossia whereby alongside the mother tongue of the speakers two or more languages are recognised for intra-societal communication with one of the languages being a foreign language, in this case English (Fishman 1971). This explains why EFL users study and aspire to use English according to the norms of a native language (including native English culture), while ELF users do not because they do not aspire to the ideal of NS of English. They adapt their interactions to their particular situations using ELF "as a transactional language for their own communicative purposes and advantage (House 2003: 560). From this point of view then, while ELF speakers have in most cases acquired English as an additional language at school and thus used to be learners of EFL, they are not seen as such in ELF conversations. Rather, in these situations they are speakers of ELF using this means of communication for their own purpose and in their own way. Therefore while EFL and ELF appear to be the same and often look the same in terms of form, these terms designate different purposes of language use.

With the advent of globalisation and the advance in science and information technology, more and more people find that they need either to communicate or access information outside their primary language group and usually do so in English. Such circumstances lead to a situation where increasing numbers of people are functionally bilingual with their language of group identity not

being the language they need for most of or at least some of their important communication acts (Wright 2004: 157-161). A case of diglossia emerges where several separate languages and codes are maintained within the same community without one sometimes displacing the other due to the different functions each serves (Fishman 1971; Lesznyák 2002). This is particularly so of English second language speakers (ESL) who find that they are required to use English on a daily basis alongside their indigenous languages.

Some reasons have been advanced for the spread of English as a world language and a lingua franca. First and foremost is the demographic distribution of the spread of the language and its apparent neutrality (De Klerk 1996; Crystal 2003). This helps in multilingual situations where there is much contention regarding language issues and various ethnic groups insist on using their own language for both solidarity and identity. For example, English became a lingua franca in multi-ethnic Singapore, with a population comprising Chinese, Malays and Indians because of its neutrality to ethnic sentiments in the diverse linguistic situation. Foley (2006) investigates the role of English from the time of British colonial expansion and observes that English functioned as an instrument of subservience before independence in 1960 but has since then changed roles to become the lingua franca of the country because it was a common language used by most people from the different ethnic groups and thus could play a neutral role. He observes that,

> English became as with many recently independent countries, a window to the world of science and technology, a symbol of 'modernisation' of the economy, a stabilising force as the only common language acceptable to all the linguistic communities that made up the new nation. The importance of such a development of English has not just been the number of people who now need or want English for these activities, but the fact that using English suddenly has little to do with one's nationality or with the historical facts of the spread of a colonial language (Foley 2006: 52).

According to this study, this policy gave tremendous prominence to English making it a bridge language and consequently led to it replacing other interethnic lingua francas such as Bazaar-Malay, as well as supplanting Hokkien, the intra-ethnic lingua franca of the numerically dominant Chinese. In the case of English in Singapore, Foley identified linguistic features at the phonological, lexical and syntactic levels that characterised this variety. These are structural aspects that have been explored in other research which indicate that there are observable innovations in the form of lingua francas in lexis and grammar (Dewey 2007b). Foley found from his study that from a syntactic perspective there was the absence of the subject and object pronoun and the possibility

of null pronouns, both of which are features from the other indigenous languages as seen in the following examples respectively:

i. After get some sickness, can't help it. ('After I get sick, I can't help it')
ii. Knows how to say, like "delicious". ('He knows how to say, words like "delicious") (Foley 2006: 54).

The phonological gap created by the presence of only five vowels in some ELF varieties such as that in Singapore, that is, /i /, /ɛ/, /u/, /a/, / c/, and the schwa /ə/ giving rise to homophonous words such as: beat/bit, pool/pull, caught/cot has been highlighted (Foley 2006: 54). Although this has no direct relevance for the present study, Foley's identification of lexical features which show evidence of hybridisation in ELF from different languages in the Singaporean context such as 'ice kachang' and 'rambutan' each refer to 'a dessert of shaved ice' and 'a small hairy fruit' respectively are relevant. Also, examples of how ELF users integrate their L1 lexical items into ELF conversations in Arabic habitat (Pölzl & Seidlhofer 2006: 160-164) are relevant. These include, 'cut' for 'overtake' and 'off'.

i. His car cut mine (He overtook me (by car),
ii. Off the light (switch off the light)
iii. And 'makan', for 'eating' (Foley 2006: 55).

Despite these differences, he observes that this variation should be seen as a sign of growing self-confidence in Singaporean identity and the variety should be analysed for its own sake rather than be taken as a poor imitation of some standard British or American English. Such evidence from other ELF contexts gives a better understanding of its occurrence in ELF in the HIV/AIDS clinic context in the present study as discussed in Chapter 5, section 5.3.2.

The different varieties of English spoken in South Africa reveal distinct phonological and syntactic features that attest to the adaptation of the language to the context (De Klerk 1996; Lanham 1996). The study highlights the presence of phonological peculiarities in Cape Flats English (CFE) such as de-aspirated stops; extreme raising of vowels and devoicing in word-final positions (Malan 1996, cited in Meierkord 2006a: 20) while Afrikaans English (AfE) displays obstruent devoicing, an epenthetic /h/ and reduced word-final consonant clusters and observe that Black South African English (BSAE) on the other hand displays a reduced vowel system and lacks the interdental fricatives /ð/, /ɵ/ and is syllable-timed (Watermeyer 1996; De Klerk & Gough 2002, cited in Meierkord 2006a: 20). Apart from these phonological peculiarities which are not explored in the present study the non-grammatical structure is evident in the present study as discussed in Chapter 5, section 5.3.2): The following examples linguistic features have been identified and are characteristic of different English varieties in South Africa:

i. The crows come and just picks out the eyes (AfE)
ii. The cops was fighting (CFE)
iii. The survival of a person depend on education (BSAE)
iv. He was good man (BSAE)
v. Wattle Park is suiting our needs so well (AfE)
vi. Men are still dominating the key positions in education (BSAE)
vii. I wasn't by the beach (CFE) (Meierkord 2006a: 21)

The second point is that English has a rich literary tradition and a varied range of native and non-native speakers across cultures. This is partly due to the fact that most of the languages competing with English do not have much literary strength in terms of published written material and/or do not have the information technology and culture that is attractive enough to foreign speakers to whom English is an elite language.

Thirdly, English has the ability to fulfil a range of linguistic functions such as communication, establishing interpersonal relationships, as well as exchanging information on various issues of social concern. These functions have been identified as the three main purposes of communication in consultations (Ong et al. 1995). Although this is a function that can be performed by any other language, there are multilingual contexts in which people still prefer to communicate or consult in English, even when they have a very limited command of the language, possibly because of issues of confidentiality in the medical setting for example (personal observation 2008).

Fourthly, the nature of the language itself has been identified as a reason for the spread of English as a world language and lingua franca (De Klerk 1996). Its proven adaptability with other languages has been instrumental in the emergence of indigenised varieties, displaying features such as code switching and code mixing (Klimpfinger 2007), coinages and the incorporations of local idioms and proverbs (Ellis 1999). This quality enables both native and non-native speakers with a basic command of the language to communicate and manage to get along. Graddol (1997) and Maurais and Morris (2003) concur with this opinion when they explain the dominance of English worldwide in its role as a world lingua franca by the fact that English possesses characteristics of diversity, hybridity and permeability that allow it to expand quickly into new domains.

Furthermore, apart from its robustness and suitability there is a linguistic reason for the spread of English as a world language and lingua franca. Maurais and Morris (2003), hold the view that the ease with which a lot of non-native speakers learn English, compared to a language like French or

German especially at the early stages, suggests that the English grammar is simpler and more adaptable.

Another reason for the spread of English in its role as lingua franca is the fact that research shows that conversations in ELF as with other lingua francas, seem to be characterised by collaboration and willingness to accept arbitrariness, giving the impression that ELF talk is overtly consensus-oriented, co-operative and mutually supportive (Firth 1990, 1996; Rasmussen 2000, cited in Meierkord 2006a: 153). The presence of transfer patterns such as the following which do not interfere with the flow of the interaction have also been noted:

i. The marked absence of the definite (e.g. Training is very long (Pakistani speaker)
ii. The indefinite article or of progressive forms (e.g. The person who was owning the shop (Pakistani speaker)
iii. The lack of subject-auxiliary inversion in interrogative construction (e.g. When you will start practising? (Zairian speaker)
iv. The non-L1 negative strategies (e.g. it's not good idea (German speaker). (Meierkord 2006a: 24)

The use of paraphrases in the form of approximations is evident and Meierkord further observes that lingua franca interlocutors use strategies such as proverbial expressions and routine formulas influenced by their mother tongues.

This section has discussed the reasons for the development of ELF as a communication tool in NN-NN interactions in some parts of the world. These include demographic details of the speakers of the language and its global distribution, its rich literary tradition, and the adaptable and robust nature of the language. The section has provided some data from existing literature that show how ELF has been adapted to particular regional contexts such as Singapore and South Africa, resulting in different varieties of the language. There is thus an indication that despite the existence of the different varieties, ELF has developed to be the preferred language of interaction between speakers of different L1s in these contexts. In the following section, I discuss English in its role as lingua franca in Africa with specific reference to some specific countries based on available literature.

2. 4.1 ELF in Africa

English has been an imperial language on the African continent since the 18th century and as in other colonial contexts, it remains dominant in former British colonial regions and it has sometimes

been referred to as an "elite lingua franca" (Kachru 1986: 907). This is because the indigenous people who gained access to higher education did so in English and so it often plays the role of lingua franca even though the people have their mother tongues (Bamgbose & Banjo 1995; Mazrui 2004; Meierkord 2006a). These studies highlight the fact that colonial education marginalised African languages especially as media of instruction and promoted European languages. This resulted in unequal divisions of power and resources between those who spoke and those who did not speak European languages. Consequently a majority of post-colonial African governments inherited educational systems with imperial languages such as English, French and Portuguese, all of which still function as official languages. In many of the African countries that were linked to Britain by colonisation, trade or religion, English became a language of contact and power in politics, a language of commerce and trade as well as a language used for the spread of the gospel (Bamgbose & Banjo 1995). It has over time assumed the status of a lingua franca because its functions have either changed or broadened. In some countries, it functions as a national and an official language because of the emphasis put on its usefulness and inevitability on the world stage (Crystal 1997; Mazrui 2004; Meierkord 2006a). However, research has indicated that the English spoken on the continent is always in L2 and ELF scenarios. Regional peculiarities resulting from the different socio-cultural and linguistic backgrounds of the users are evident. Some studies show that English in this context has been Africanised and nativised, recognising African perspectives on the language based on local conditions, needs and experiences (Bamgbose & Banjo 1995; Mazrui 2004). The Cameroonian experience, for instance, reveals that English is spoken in the context of an official language policy that recognises French/English bilingualism while still having a multiplicity of indigenous languages that people use for everyday activities in various parts of the country (Bamgbose & Banjo 1995; Njweipi 2000). A variety referred to as Pidgin English functions as lingua franca in most parts of the country and as it does in most of Anglophone West Africa as a medium of communication especially among people who do not share a common L1 or who have had no formal education (Dolphyne 1995, cited in Bamgbose & Banjo 1995: 30). Although English is one of the official languages in the country, it is spoken along-side the numerous mother tongues in the country as a common language with a hybrid form in formal and informal situations. Such interactions give rise to the different varieties of English that function as lingua franca in the country even though these varieties of English do not necessarily represent all ethnic groups. Features regularly associated with ELF and cross-cultural communication, such as code switching, literal translation and new coinages are as present here as they are in other multilingual countries using ELF as a common language.

In Nigeria, the history of the English language dates as far back as the 16th Century when it was first used between European traders, British missionaries and the locals (Bamgbose & Banjo 1995). They note that ELF in Nigeria developed from a contact situation between English and the Nigerian languages in that socio-cultural and political situation. English is now a national language and one of the four official languages of the country, but solely enjoys the status of lingua franca due to the rivalry between the three indigenous languages that are official, that is, Igbo, Yoruba and Hausa. With such a language policy, there is bound to be some level of competition between the languages in terms of what functions they perform and between the users who try to maintain the dignity of their own ethnic languages and identities. This linguistic scenario reflects what De Swaan's (2001) finding points out that sometimes it is not really about the right of individuals to speak in the language of their choice, but about, "… the freedom of everybody else to ignore what they say in the language of their choice" (De Swaan 2001: 52). He goes on to say that, "if one wants to communicate beyond one's own local circle, one will have to learn a language which links one with wider circles of communication, with a language with a high communication value" (De Swaan 2001: 33). I think it is this kind of contention in the Nigerian context that makes it easier for most people to choose to use ELF for its neutrality in cross-cultural communication.

English is the official language in Ghana too, where it competes with 42 indigenous languages (Dolphyne 1995, cited in Bamgbose & Banjo 1995: 27). This study reports that the Ghanaian government sponsors the publication of materials in ten languages, but English is the preferred medium of communication for government business in meetings at national, regional and district levels. No matter what other Ghanaian language is used in a meeting, the minutes of the meeting are always written in English. This clearly shows that because of the same reasons discussed above, i.e. that English is a common language that has been learnt widely, has a high communicative value and is used in intercultural interactions. However, it functions as a lingua franca both in a competitive and a complementary way with the other English varieties as well as other languages. This is illustrated when even in churches the sermons are delivered first in English and then translated into a Ghanaian language, depending on the audience (Dolphyne 1995, cited in Bamgbose & Banjo 1995: 29). In this context therefore ELF and English can be used interchangeably.

The above emphasises that English has developed the status of lingua franca in cross-cultural and international communications in many multilingual communities in Africa. In South Africa its role is a little different from the Cameroonian and Ghanaian cases mentioned above even though the indigenous languages in these countries do not have the same official status as English. In terms of

the official language, the South African linguistic situation is to a considerable extent similar to the Nigerian case because some of the indigenous languages are constitutionally awarded the status of official language along-side English, giving rise to the kind of competition I mentioned earlier in the Nigerian case. South African English (SAfEng) has different varieties and accents, such as Black South African English (BSAE), Afrikaans English (AfE) as well as Cape Flats English (CFE), which developed as a result of the different mother tongues of the different prominent ethnic and cultural groups (De Klerk 1996; Trudgill & Hannah 2002). For the purpose of this research, I consider any intercultural interaction in any of these varieties an ELF interaction. Attitudes towards these varieties and their use range from indications of acceptance, solidarity, superiority and assertion to exclusion, rejection and inferiority (Kaschula & Anthonissen 1995; Smit 1996). These researchers observe that the cultural and linguistic diversity in the country is reflected in ELF through translinguistic markers such as loan words, interferences and code switching which are common features in intercultural communication. These markers constitute the linguistic qualities of hybridity and permeability (Maurais & Morris 2003) alluded to in section 2.4, which facilitate the development of English as L2 in particular and as lingua franca in general.

The language situation in South Africa during the political transition from the mid-90s to date has seen an increased sensitivity to and awareness of languages and language rights, owing to the language policy in the 1996 Constitution of the Republic of South Africa, which recognised and gave equal rights to English and Afrikaans (the two official languages of the former regime) and additionally to nine indigenous African languages. Section 6(1-5) of this constitution thus, recognises 11 official languages. In fact, English is so widely used in public spaces that is seems to have become the unofficial lingua franca. As in many countries worldwide, many more people use it across cultural boundaries than any of the other official languages (Graddol 1997: 13; Crystal 2003: 61). The country's language focus has moved from attention to Afrikaans and English to take on a larger concern about the ecological diversity of South African languages which are now seen as treasured cultural possessions that may be under threat due to the wider use of English (De Klerk 1999: 316). In an earlier study she indicated that language in South Africa had become a terrain of struggle where people exercised their basic human right to express themselves in their own mother tongue (De Klerk 1996). This contention is evident in popular media in the country and indicates that inter-cultural communication is essentially organised in direct response to social needs such as health care, public security and education (Buhrig & Ten Thije 2006). However, despite this contention, ELF functions in the HIV/AIDS clinics in the present study as a 'fall back' option in situations where the other indigenous languages do not enable communication

It is evident that like elsewhere English in South Africa does not have one defining context but cuts across many contexts, cultures and languages (Mesthrie 2002). It is manipulated in each context differently, either as a medium of power and authority, as medium for cohesion, or simply as a means of communication. He indicates that as a language of power, English is used for international communication in diplomacy and has been found to offer more opportunities to those who can speak it than those who cannot, whereas as a medium for cohesion it enables people from different linguistic backgrounds to be able to live and work together by communicating in a language that is neutral. Thus, English functions as ELF in Africa and has changed in form and function since early contact through colonialism, trade and the spread of Christianity. However, the conceptualisation of contact in these countries where ELF is used today is different because currently contact mostly occurs due to inter-ethnic and cross-cultural mobility and not just as part of a colonial governmental program within the countries, as evident in the linguistic situation in the four African countries discussed above, that is, Cameroon, Nigeria, Ghana and South Africa.

2.4.2 English in the Western Cape

In this section, I discuss the use of English in the Western Cape of South Africa considering the fact that my research sites are located in this area. So, I focus on the language policy of the province and explain the circumstances under which ELF becomes operational as well as describe the portion of the population that is represented in my study.

Although English has official status in South Africa, it is used by many mostly as a second language and lingua franca. It is important to note here that although the following statistics are from two different sources and covering different areas of the population, they are used to highlight the fact that language issues are investigated by various groups for various purposes. This also highlights the fact that data for language issues in HIV/AIDS is based on these general statistics but nonetheless relevant and provide understanding of issue under study here. Based on the 2001 census (Statistics South Africa 2003) national statistics, the three most prominent languages spoken in the Western Cape are:

8.2% of the South African population spoke English,

13.3% of the South African population spoke Afrikaans and

17.6% spoke isiXhosa.

Meanwhile, the language profile of the Western Cape (Statistics South Africa 2006) indicates that:

19.3% of the population spoke. English,

55.3% of the population spoke Afrikaans and

23.7% of the population spoke isiXhosa.

These statistics reveal that the languages that are used in the Western Cape in ranking order are Afrikaans, isiXhosa and English. The statistics for the home language of the population in the municipalities from the same census indicates that the Boland municipality to which the specific site of my research belongs indicated that:

78.8% of the population of the semi-rural town were Afrikaans speakers,

3.2% of the population of the semi-rural town were English speakers, and

16.7% of the population of the semi-rural town were isiXhosa speakers

1.4% of the population of the semi-rural town were speakers of other languages.

These figures point to the fact that most of the inhabitants of the Western Cape are proficient in Afrikaans and isiXhosa as L1 and only a small percentage speaks English as their L1. However, from experience, in most multi-lingual situations in the Western Cape in which interactants use mutually unintelligible languages English is often the preferred lingua franca. These statistics thus are indicative of the fact that most people in this area use English as ELF in communication across cultural and linguistic divides and most likely also in specific circumstances such as for consultations with doctors whose L1s are different from theirs or for communication with other nationals.

Regarding the different functions performed by South Africa's languages including English, Mesthrie (2002) presents an overview of the history, language interactions and language policies; highlighting the fact as these languages co-exist and function in a complementary manner especially from 1996. De Klerk (1999: 315) reveals that these languages constantly change in form and function in response to the needs and demands of society resulting in features such as borrowing, code-mixing and code-switching. Some of these pulls and pushes would relate to issues of health care, the aspiration to belong to a higher prestige social class, education, and politics. Each of the languages in such a multi-lingual context expresses and supports a different set of behaviours, attitudes and values that are culturally legitimate and complementing each other in a non-conflictual manner (Fishman 1971). In the case of the Western Cape, Xhosa and Afrikaans speakers, use their languages for intra-group communication, solidarity and identity, but use English to communicate with foreign nationals or with people from other ethnic groups. In a situation like the HIV/AIDS consultations in the data interactants may have personal reasons for using a particular language, such as a patient preferring to use a L2 rather than sacrificing confidentiality in using L1 or soliciting the help of an interpreter. English operates in this complementary way with most of the other ten official languages in South Africa.

The language situation in the Western Cape, especially the use of ELF has been influenced by socio-political changes in South Africa as a whole. As Wright (2004) observes, whatever the reason for contact, the linguistic outcomes will be different in each case and will provoke different behaviour practices. With the inception of democracy in South Africa in 1994 and the banning of Apartheid laws (e.g. the Group Areas Act of 1950, the Coloured Labour Preference Act of 1954 and the Pass Laws), section 21(1-4) of the South African constitution of 1996 granted the citizens freedom of movement and settlement. Consequently, there has been an influx of people with L1s that are new to the region to the cities in search of jobs, education and a better life. The Western Cape is one of the target provinces of this influx. Many of these newcomers are black workers, mostly poor-Xhosa-L1 speakers from the previously disadvantaged rural townships (Williams 2006). It has been indicated that most of the people who recently relocated from rural areas possess a very rudimentary knowledge of English which is not only the major working language in the city but also one with an elite status. Typically, the people who attend HIV/AIDS clinics come from this community. Often, the patient's L1 is different from that of the doctor's. In a complex linguistic situation like the one described above, one would expect that the interactants would in a contact situation solve their communication problems by doing what some studies suggest, that is, either by developing an interlanguage which both sides employ or by one group or a section of a group learning the other's language (Wright 2004: 101). However, this is not applicable here due to the fact that the language contact situation in the Cape has lasted a long time and is not expected to always be the case when multilingual speakers meet and interact. The decision to use a third language in such instances that is not the primary language of either of the interlocutors, one in which both participants have varying degrees of competence is usually a welcome option. This is an illustration of where ELF would be used for mutual intelligibility and not for identity purposes or for prestige. Bearing this in mind, I would say that although the population of this region is mostly made up of Afrikaans and isiXhosa L1 speakers, there is a significant group of the population that relies on ELF for interpersonal and business transactions because their L1s are different. These people regularly find themselves in communication situations that require a lingua franca and although Afrikaans is the L1 most widely represented in this province, ELF functions as the lingua franca in such situations. In the next section, I consider issues relating to misunderstanding in such interactions.

2.5 Issues of misunderstanding in lingua franca communication

Misunderstanding has been defined as "a potential breakdown point in conversation or at least a kind of communicative turbulence" (Mauranen 2006: 128). In this study, non-understanding would

embrace this definition and include particularly linguistic aspect of communication that lead to any lack of understanding. This is a phenomenon that can occur in any form of communication. However, lingua franca interactions are presumed to be more prone to misunderstanding than L1-L1 interactions. There is evidence that interlocutors in lingua franca communications generally achieve communicative success despite the fact that they cannot rely on a stock of previously agreed-upon norms of linguistic behaviour or shared knowledge either of the code or cultural schemata (Pölzl & Seidlhofer 2006: 151). Research (Firth 1990; Pitzl 2005; Mauranen 2006; Meierkord 2006a) shows that mutual understanding in ELF interactions is often achieved through careful and laborious negotiation which involves repetition and elaboration, paraphrasing and reformulation, maximising simplicity and displaying reciprocal engagement at the interpersonal level. These studies suggest that there is surprisingly good understanding between participants who communicate through the medium of a lingua franca. However, they indicate that some misunderstanding still occurs in these lingua franca interactions albeit infrequently resulting sometimes in a breakdown in communication.

Misunderstanding in lingua franca has often been studied in interactions from the perspective of native-non-native speakers, usually emphasising the defective form of contribution of the NN interlocutors and their lack of pragmatic competence (Mauranen 2006). Her study (2006:124) notes however that the L1-L2 scenario often depicted in analysis of misunderstanding is asymmetrical in nature with regard to the command of the target language. This is because misunderstanding in such situations is often blamed on the L2 speaker. Therefore misunderstanding in these scenarios cannot be compared to a scenario of non-native-non-native (L2-L2) communication as is generally the case with ELF interactants, like those investigated in the present study because none of the speakers is a native speaker of the language. It is understandable that with the advent of globalisation, the L2-L2 interactive scenarios are a more common occurrence and require investigation. Mauranen's study investigates L2-L2 interactions in the academic context in which the speakers have a domain-specific English repertoire of which its members have to be familiar. This evokes the concept of a discourse community and can use the ESP approach suggested by Hüttner et al. (2009: 102) to enable the understanding of specific academic genres. Individuals teaching or studying such academic genres would constitute a discourse community. This study discusses instances of misunderstanding in a specific academic discourse community, how they are signalled and how a noticeable effort is made to resolve or avoid them (Mauranen 2006: 132-138). Such research is relevant to the present study in that it analyses ELF interactions between individuals from diverse linguistic backgrounds where English is not their local or first language. However, whereas the study above explores communication and misunderstanding in ELF use in an academic

environment, my study investigates similar patterns in a particular medical context, that is, HIV/AIDS consultations in selected clinics.

Causes of misunderstanding in ELF can be attributed to the socio-cultural and linguistic behaviour of interactants considering the fact they come from diverse backgrounds. For example, Mauranen (2006) and House (1999) attribute some instances of misunderstanding in ELF to a lack of communicative and interactive skills such as shared knowlege that may cause interlocutors to fail to assign satisfactory interpretation to certain expressions. Mauranen highlights linguistic problems related to the structure and phonology of ELF which result from what she calls 'variable learning' since the interactants learnt the language in contexts presenting local differences in teaching material, teaching practices, teacher qualifications and ideologies of learning which cause a variation in their ELF repertoires (Mauranen 2006: 126-127). The strategies for signalling and resolving misunderstanding in the academic context can shed light on the understanding of the ELF interactions in the HIV/AIDS consultations under investigation. This dissertation will investigate how the interactants try to prevent or overcome misunderstanding in various ways such as the process of simplification of the structure of the language, detailed explanation, the use of local metaphor and analogy, code-switching and so on.

Differences in cultural backgrounds can cause misunderstanding because the interactants have different world views. When people travel and migrate, communication becomes more intercultural and misunderstanding sometimes threatens the communicative success in such encounters. This is often the case with lingua franca communication (Buhrig & Ten Thije 2006). However there is evidence that misunderstanding is not bound to occur at all times that people of different cultures meet, because languages possess communicative strategies that speakers use to signal and resolve them such as confirmation checks, repair requests and requests for clarification (Lappalainen 2001; Buhrig & Ten Thije 2006). In this way speakers aim at mutually acceptable and comprehensible ways of expressing their intended meaning.

There is ample evidence from available literature that misunderstanding in lingua franca interactions can be prevented or avoided (Firth 1990; Bae 2002; Mauranen 2006). Topic management and the way it relates to misunderstanding, is one of the ways in which this is done. According to Pitzl (2005: 56), when misunderstandings do occur, they can be signalled and resolved through direct and implicit procedures such as reprise, minimal queries and reformulation, repetition and rephrasing. Mauranen (2006: 135-138) also indicates that interactants in lingua franca communication use various strategies to prevent and signal misunderstanding such as

interactive repair, clarification checks, questions and the repetition of problematic items. Furthermore, apart from topic management, interactants can prevent and avoid misunderstanding in ELF communication merely because such interactions are overtly consensus-oriented, co-operative and mutually supportive (Firth 1996; Mauranen 2006) since both interactants actively engage in negotiating mutual understanding (see *Chapter 5, section 5.2.3*). Often, the interlocutors adopt a behaviour that has been described as the "let-it-pass principle" (Firth 1996: 243-245). They are already aware of their shortcomings as "they anticipate such difficulties, and attempt to offset this by working harder toward mutual understanding" (Mauranen 2006: 124). These studies reveal that interference from L1 interactional norms is rare, that is, expectations regarding the norms of interaction seem to be suspended positively as the expression of cultural identity. The present study however is not investigating the different cultural norms that govern the interaction but will explore cultural and linguistic influences of their L1 on ELF (see *Chapter 5, sections 5.3.1* & *5.3.2*).

In Mauranen's (2006) investigation of misunderstanding and its prevention among participants in university degree programs using ELF, she finds that interlocutors achieve important communicative goals by engaging in various clarification and repair strategies in an effort to achieve mutual intelligibility (see *Chapter 5, section 5.2.3*). This she observes is done on the basis of the assumption that lingua franca communication is susceptible to misunderstanding because participants' command of the language is imperfect and there is little certainty about sharedness. She however points out that, it is plausible that not much is misunderstood since interlocutors tend to maximise simplicity in their expressions partly because their command of the vehicular language is imperfect and partly because they expect their interlocutors to do the same (Mauranen 2006: 123-124). Bearing this in mind, she notes that speakers in intercultural communication strive toward mutual understanding.

Buhrig and Ten Thije (2006) on their part found out that instances of miscommunication among matched interlocutors (like in L1-L1 interactions) are not often reported as they would be if the interlocutors are unmatched (L1-L2). When interactants share an L1 their misunderstandings are often considered as not being socially significant and thus are harmless. To support this observation they refer to the miscommunication and the resultant misunderstanding and confusion that occurs in faculty meetings where the hearer rarely blames the speaker for the miscommunication but rather assigns the blame to other sources of error such as not hearing right, not paying attention to the medium used and even to interferences (Buhrig & Ten Thije 2006). Such assumptions give the erroneous impression that miscommunication between matched interlocutors should not be construed as such. However, they echo the 'let it pass principle' that was mentioned earlier which

ironically is a feature that apparently operates typically between lingua franca users. But, when there is a mismatch in the interlocutors in inter-ethnic communication, the dominant interlocutor mostly blames the minority language speaker when miscommunication occurs without any consideration of his/her own characteristics, as being, for example, a bad communicator; rather s/he attributes this to the other's membership of a different and(even socially inferior) group (Garcia & Otheguy 1989). This type of miscommunication increases the stereotyping where the speaker is not judged by his/her communication capabilities but by virtue of his/her being a member of a maligned group, which impedes the communication even further (Gumperz 1982). Subsequent research has, as was indicated earlier (see *section 2.2.1*), shown a shift from this exonormative approach that puts the NS on the pedestal to the endonormative one that considers the lingua franca user as a language user in his/her own right (Meierkord 2006a; Crystal 2001; Seidlhofer 2000). This study suggests that miscommunication in lingua franca communication must be treated as such without any consideration of whether the interactants are L1or L2 speakers. This approach has inspired the particular conceptualisation of ELF as it is used by the participants in the present study, to be a code developed on its own terms and in its own right.

An area of inter-ethnic or cross-cultural communication that has been the focus of much recent research refers to the lack of knowledge that each group has of the other. Research (Garcia & Otheguy 1989), shows that successful communication in such situations can only occur if both interlocutors understand each other's cultural and linguistic background, although this is not always the case. The interactants in this research for instance lack both a shared L1 and cultural knowledge and this is compounded by the fact that they express themselves in different varieties of English (BSAE, CFE & AfE). This in itself has been found to greatly impact inter-ethnic communication (De Klerk 1996) because sometimes speakers use English forms to parallel familiar messages normally transacted in non-English languages. This becomes a problem because they may lack the vocabulary to express some of the English concepts in their L1 like the use of the words *sea dog* and *iviral load* in the data for the present study. It has been noted that when interlocutors operate in a language that is not their own, their language use is governed by communicative systems or rules that they already have at their disposal (Garcia & Otheguy 1989). This could explain why, when the communicative system in an L2 is limited, interactants immediately fall back on their L1 system that is familiar to them and transfer rules of their own L1 to what seems to them a corresponding situation in ELF or L2. Garcia and Otheguy (1989) note that such communicative transference and literal translation can be a source of misunderstanding during inter-cultural communication because the message conveyed may not be the one intended. This can be very frustrating to both interactants particularly if there is evidence of misunderstanding which the participants struggle to manage due

to their limited competence in the rules of the chosen language. But they also point out that previous research on cross-cultural communication in face-to-face interaction indicates that the choice of linguistic code and grammar are not a major source of misunderstanding (Garcia & Otheguy 1989). Misunderstanding in lingua franca communication can also be caused by words that are phonologically similar or identical such as beat/bit, bed/bet, seat/sit, and can occur in the same context because such words can be interpret wrongly them in the other code. The linguistic code in the present study is ELF and there was no misunderstanding resulting from the use of any such words. However, it is interesting to see how interactants resolve misunderstanding that arises from their different linguistic backgrounds (see *Chapter 5, section 5.2.3*).

In this section, I have defined and discussed aspects of misunderstanding in lingua franca communication paying attention to how it is dealt with in ELF research. I have also discussed some relevant literature on this topic indicating their findings in this regard and how they relate to my study. Particularly, I found Mauranen's (2006) investigation of various ways of signalling and preventing misunderstanding inspiring because she extended the scope of misunderstanding from those that were explicitly recognised and signalled by the interlocutors resulting from "retrospective" behaviour to include what she termed "prospective" (Mauranen 2006: 131) behaviour which involves the advance prevention of misunderstanding based on bolder guesses about speaker behaviour and indirect signalling through confirmation checks, interactive repair through frequent requests for clarification and rephrasing, as well as self-repair by providing additional explanations.

2.6 Summary

This chapter has discussed the definition and use of lingua francas, discussing the circumstances that generally coincide with their creation as well as the roles they play in some countries. In these countries ELF comes through as the language of preference, and is often rid of any tensions that are a result of ethnic affiliations. It appears to be relatively easier for people to acquire, even though they might not be formal/-ly exposed to it. This is probably related to the status and prevalence of English and the social value knowledge of the language has rather than to inherent qualities of the language itself. I discuss the recent research interests and trends in lingua franca research, highlighting the fact that there has been a considerable shift in focus over time. The chapter has provided a conceptual frame-work for ELF in the study as a language of communication, a common language, and a neutral language, explaining the relevance of a concept such as 'community of practice'. This is particularly apt because the participants in the present study come from quite

diverse circumstances, economically, socially, culturally and educationally, and this particular operational framework seems to cater for these varied backgrounds that factor in the consultation. The review of literature has also discussed the function of ELF with reference to a few countries, highlighting the fact that the language has developed peculiar characteristics depending on the socio-cultural and geographic context. The discussion has revealed the confidence with which these regional varieties are asserting themselves as in Singaporean, Nigerian, Ghanaian and the different varieties of South African English. The peculiarities are mostly to be seen at the phonological, lexical and even at discourse levels. However, this research concerns itself with the lexical and discursive aspects of the conversation during HIV/AIDS consultations. I proceeded to discuss ELF in the Western Cape to enable readers contextualise the study. In this chapter too, I have defined and operationalised misunderstanding in the study and discussed some of the relevant literature on the investigation of misunderstanding in lingua franca communication. The following chapter on conversation analysis and discourse analysis provides a theoretical framework with which to describe and examine the consultations conducted in ELF.

CHAPTER THREE
THEORETICAL FRAMEWORK: MEDICAL DISCOURSES

3.1 Introduction

This chapter elaborates on aspects of particularly spoken discourse that are pertinent to the analysis of ELF doctor-patient consultations and the summary of results of the study that will follow in chapters 5 and 6 respectively. It explains the term 'discourse' and the theoretical frameworks and approaches that have been used in research on medical discourses, and in particular those used in doctor-patient communication. An exposition is given of CA and DA as the theories that underpin the analysis of the data in the present study. CA and DA are both discourse theories in their own right working from different points of departure and are used for different analytic purposes. However, they are linked because they work with similar definitions of 'conversation' and 'discourse' as a basis for analysis. I draw on analytic instruments from both of these frameworks in discussing issues such as the relationship between language and context. CA is useful in defining the interactional rules and features such as turn-takings, sequences and repair strategies that participants use to create social order during doctor-patient interactions. I further discuss the impact of interactants' cultural backgrounds on their discursive and communicative competence in the medical context of a clinic where ELF is used for consultation using DA. The discussion highlights the shift in research trends in medical discourse from the biomedical and paternalistic approaches to the patient-centred and partnership models that have been advocated in the last two decades in doctor-patient interactions. Furthermore, the chapter examines genre theory, highlighting the dynamism and fluidity of different types of genres. The inconsistencies and shortcomings of genre classification are revealed. This shows that interactants at a particular time and place can employ one or more genres in the same text especially in face-to-face interactions. In this chapter, medical discourse is conceptualised as a genre and consultations as a text type that falls under this genre. In this regard, I discuss the different sub-categories identified in medical consultations and seek to discover how these play out in the HIV/AIDS consultations in ELF in this study. Finally, I highlight the strengths and weaknesses of these theoretical frameworks with regard to studies on doctor-patient communication.

3.2. Discourse

The term 'discourse' has been defined differently by different people in different contexts (Nixon & Charmaine 2007; Buus 2005; Fairclough 2003; Todd 1993; Cook 1989; Foucault 1988). Generally

it refers to any form of interchange of ideas that might be text-based, language-based or nonverbal. It has multiple perspectives that underpin the various definitions in various disciplines, for example in Literature, Sociology, Psychology, Linguistics and Applied Linguistics (see Nixon & Charmaine 2007; Buus 2005).

From the literary perspective, stylisticians generally accept that literary texts are examples of language in use and they draw on discourse models that explore the content and context of interaction in the study of literature as well as the social relationships of the interactants at the time (Simpson 1998: 237). Discourse has been perceived in this way from the Foucauldian perspective to refer to specific ways and not others, in which "we can write, speak or think about a given social object, practice or positioning at particular historical moments" (McHoul 2006: 681) or even how we discuss particular topics such as HIV/AIDS. From this perspective, discourse constructs a topic and governs the way it can be meaningfully talked and reasoned about. This implies that different discourse types determine the language used in talking about them and that they will include statements and topics relevant to the area of knowledge that is involved. It also implies that there are rules and practices that make the occurrence of certain statements possible and others not, and that there is a prescribed way of talking about these topics to the exclusion of others at particular times, places, institutions and locations. Seen from this point of view, HIV/AIDS discourse will include topics and statements relating to HIV/AIDS as well as related medical concerns. The interactional rules such as turn-taking and sequencing will reflect the nature and purpose of the interaction. In other words, HIV/AIDS discourse and medical discourse in general, will have peculiarities that distinguish them from other forms of discourse that take place outside the medical context, such as light everyday conversation or a lecture. Foucault (1988: 15) further perceives discourses as bearers of various subject positions of agency and identity in relation to particular forms of knowledge and practice. This implies that at any particular moment, both interactants and what they are doing can be identified from what they say in relation to the topic under discussion. He suggests that in discourse people locate themselves in the position that makes most sense to them, thereby subjecting themselves to the meanings, power and regulation of such a discursive position. Therefore, the position that people have either as patients or doctors in a medical discourse represents their knowledge and the power they wield during such interactions. He posits that the subjects in these positions are discursively structured and created in interaction through their cultural meanings and practices, occupying various culturally-based sites of meaning. Thus, participants are constructed as family members, male or female, doctors or patients, fathers and mothers, learners and teachers, with every site evoking a different configuration of self and a different kind of language use. Although the scope of Foucault's notion of discourse is general, the

perception of discourse in the present study relies on his view that discourse is a bearer of different subject positions of agency and identity in relation to medical knowledge and practice. The present study thus investigates language use to identify how discursive structure discloses the social roles the participants play and the manner in which this is done. Thus, it investigates the linguistic features through which meaning is transmitted in the doctor-patient consultation in the specific context of the HIV/AIDS clinic. This study assumes that linguistic reality is mediated and is governed by the way language works, our knowledge of the discourse and the way we speak about a subject under discussion since we can only speak of what we have language for and only in ways our rules of discourse allow us (Foucault 1988: 46-47).

From the social interactive perspective, researchers perceive discourse in terms of sequential properties of interaction which interactants use to establish social order. This view shows that spoken discourse when analysed after the event, has more order and form than might appear at first as it was believed (Todd 1993; Ochs 1979). This may be the reason that some linguistic formalists of the 1960s, such as Chomsky (1965) were reluctant to take spoken discourse or conversation as material for in-depth structural analysis. They found such discourse to be disorganised, often less planned and disorderly since its form is determined by much that is non-linguistic. But those who view discourse from the social interactive perspective argue that the analyst at this point has the benefit of hindsight since he/she is working with transcriptions of already completed communication events, done with some knowledge of grammatical and communication rules. However, conversation and discourse analysts found that certain types of spoken discourse such as lessons, lectures and interviews share typical features which show internal organisation and well-plannedness associated more clearly with written discourse. Some studies have indicated that even the most informal conversation is systematically structured and orderly (Cook 1989).

In Applied Linguistics, discourse studies investigate how lexico-grammatical forms take on meanings in particular contexts, seeking to match form and function. For example from a pragmatic perspective researchers are interested in what people mean by what they say, what is intended as opposed to literal meaning of words in a particular contexts. This is opposed to Richards and Schmidt's (2002: 174) approach which defines discourse in terms of semantic meaning, that is, dealing with linguistic meaning in a way that does not consider the users, the purpose or context of communication. To discursive psychologists such as Potter and Wetherell (1987, 1992) discourse is construed in terms of its constitution as being both text and language based. Their work emphasises the use of acknowledgement tokens and gambits such as, *you know*, *you see*, *I mean*, as well as that of other connectives such as *however*, *then* and *furthermore*, that smoothen conversation is

emphasised. This implies that those who analyse discourse from this perspective recognise that discourse is text-based, language-based, as well as non-verbal. This implies that there is more to discourse than just the written and spoken language since non-linguistic signs such as gestures and facial expression, as well as sounds that may signal agreement or disagreement, satisfaction or dissatisfaction are an integral part of the discourse.

In conclusion, considering the fact that medical discourse covers a wide range of situations such as conversation, commenting on reports, asking questions about procedures, where participants may be doctors, patients, nurses, interpreters and pharmacists and medical researchers, the above conceptualisations of discourse are relevant to the study of the HIV/AIDS consultations as a form of discourse. The above discussion focuses on discourses in general but the main concern of this research is specifically on the nature and characteristics of HIV/AIDS discourse in ELF.

3.2.1 Research approaches used in medical discourse

This section discusses some of the approaches that have been used in previous investigations of medical discourse and doctor-patient interactions in particular, giving some historical background to work in this field. The discussion aims to justify the approach that I have chosen to use in the present study since doctor-patient communication is just one of the numerous genres of medical discourse and health communication.

The theoretical approaches and methods that are used in any given study are often determined by the research questions and objectives. The approaches and methods used in the study of medical discourse are as diverse as the theories and disciplines that are interested in this area of research. For example, the bio-medical approach in which health is viewed primarily as a biological phenomenon has been used by some researchers in disease symptoms in western medicine. This approach highlights what has been referred to as “the voice of medicine” (Mishler 1984, cited in Wodak 2006: 682). It is doctor-centred because research that uses this approach emphasises the viewpoint of the experts. Thus, the asymmetrical relationship between doctor and patient is highlighted with the doctor representing the authority seeking information about the patient’s complaint, making a diagnosis and prescribing treatment. This is different from the patient-centred approach (to be discussed below) which engages the patient’s life world and builds a discourse with the doctor showing empathy by listening to the patient’s experiences, eliciting his/her feelings paraphrasing and reflecting (Ong et al. 1995: 904). However, although I believe that the patient-centred approach is more humane, I acknowledge the fact that both bio-medical and socio-relational

aspects are necessary. This is emphasised through the three-part discourse sequences identified as the bases for such interactions: asking questions, answering and expressing acknowledgement (Coupland & Adam 1997).

The micro-analytical linguistic approach has been used in research on medical discourse. It emphasises the communication strategies used during the medical interview which could be either doctor-centred or patient-centred. For example, Barrier et al. (2003) presents a detailed discussion on how a medical interview can be analysed using the physician-centred and the patient-centred approaches. The study shows that using simple phrases such as "what else?"(2003: 212) and "you seem very sad (angry, upset, tired etc)," (2003: 213) as a means to allow the patient to tell the whole story and reveal more information indicates the doctor's acknowledgement of the patient's emotions. This study also presents the Roter's (1991) system which will be discussed below. Such analyses enable the researchers to understand communicative strategies that both doctors and patients use to facilitate interaction and build a good relationship during interaction. Still following the micro-analytic approaches from the medical and linguistic perspectives, other studies explore how social variables such as sex, age and social status influence the progress of the interaction (Fisher & Todd 1986; Irish & Hall 1995; Fisher 1995 all cited in Cordella 2004: 26). These social variables influence the use of linguistic strategies such as questions and turn-taking in the context of medical practice. Some researchers (Cordella 2004; Watermeyer 2008) have argued in favour of a hybrid approach showing that macro-analytical and micro-analytical approaches of doctor-patient interactions complement each other and may shed the most light on such communication. An understanding of the socio-economic background of the participants and the linguistic resources available to them are helpful in the analysis of data using such approaches.

Sociolinguistic approaches have been used in research in medical discourse and have focused on the miscommunication that occurs in the clinical setting in a multilingual context. Miscommunication appears to increase when two different languages and/or cultural groups interact (Cordella 2004; Buhrig & Ten Thije 2006). This might be revealed in the present study in the case of English, Xhosa and Afrikaans. But there is no guarantee that misunderstanding will necessarily disappear when participants are from the same cultural group or when speakers of the same language interact which is not the case in the present study. Buhrig and Ten Thije (2006: 189) for example point out that misunderstanding can frequently be found in intercultural communication although one couldn't claim that such communication is constituted of only of misunderstanding. This stance is relevant to the present study because the interactants come from diverse cultural and linguistic

backgrounds and manage to conduct consultations in ELF and reach a reasonable amount of understanding.

In a review of different approaches used in the analysis of doctor-patient communication, three main purposes of communication in consultation were identified, namely: creating interpersonal relationships, exchanging information, and making treatment related decisions Ong et al. (1995: 904). They then linked these to different systems of analyses. The Bales' Interaction Process Analysis and the Roter's Interaction Analysis System (RIAS) (Roter & Hall 1992) for example, are both methods that capture the interaction between doctors and their patients. Here data from transcription of audio and video tapes and direct observation were used (Ong et al. 1995: 907). Some of the research in doctor-patient interaction uses an approach in which the researcher presents and focuses on the actions of the doctor and anatomises the primary care visit into various stages (Bensing 1991). Bale's system mentioned above for example, focuses more on what has been called the "cure" systems which capture instrumental or task focussed behaviour (Ong et al. 1995: 906) and is therefore doctor-centred. This approach characterises and categorises the doctors' behaviour at each stage of the consultation, revealing their expertise and authority in both the interaction and its outcomes, but presents the patient almost as a passive participant that is being controlled through the interaction by the doctor. Researchers who use this approach view the doctor-patient interaction from a paternalistic standpoint because the doctor is depicted playing the parent role. The doctors exhibit communicative behaviours such as giving information, asking questions, counselling, identifying future treatment or tests, discussing test results and side effects of treatment as well as taking the primary responsibility in decision-making (Balint & Shelton 1996, cited in Potter & McKinlay 2005: 466). A feature of this approach is that it is not specific to a clinical situation and was developed for research in small group discussions to investigate problem-solving behaviour. Although the doctor's perspective is of crucial importance to the doctor-patient interaction, this system of analysis is not relevant to the present study because it is one-sided since it doesn't give the patient's perspective.

Another approach that has been used in analysing doctor-patient communication is the patient-centred approach which reflects the 'care' systems and seeks to explore the affective or socio-emotional behaviour in doctor-patient interactions (Ong et al. 1995: 906). This approach investigates aspects of the interaction which reveal "behaviors directed by the doctor towards the patient as a person rather than as a case" (Ben-Sira 1980) or "behaviors designed to establish and maintain a positive relationship between the doctor and his patient" (Buller & Buller 1987) all cited in Ong et al. 1995: 906; see also Mead & Bower 2002). Such behaviours have been investigated in

previous studies and are evident in utterances that depict the doctor as being encouraging, relaxed, friendly and honest or as showing concern, being reassuring and empathetic or introducing self to patient, addressing patient by first name, providing verbal support and engaging in small talk (Blanchard et al. 1983, cited in Ong et al. 1995: 906). But it is understandable that not all medical problems can be solved by the affective or instrumental behaviour. Some of them relate to language use which is an area that this study is going to explore. Despite the similarity in the Bale's and RIAS approaches in terms of capturing the doctor-patient interaction, the RIAS has been found to be more realistic than Bale's approach. RIAS is based on the Bale's system and it is specifically modified for the clinical setting. It is an integrative approach that captures both the instrumental and affective behaviour of the interactants. Both approaches are used in doctor-patient interactions and will be relevant to the present study. However, the analysis of my data will not be based exclusively on either one of them because the scope of the analysis goes beyond investigating the language used to discuss the cure and care of the patients. My interest is also in exploring how the socio-cultural and linguistic contexts of the interactants affect the way in which this cure and care is sought. Therefore, my study will benefit from any aspects of the approaches that would shed light on the understanding of my data. It is important to note that unlike the Bale's system my study is specific to a clinic setting and it differs from Bale's and Roter's approaches in that it investigates only the spoken and not the non-verbal features of the doctor-patient HIV/AIDS consultations.

Many researchers have supported the use of integrative approaches. For example, following in the path of Roter's (1991) RIAS, Heritage and Maynard (2006) recently used an integrative approach that works from the sociological and interactional perspectives. They argue that the doctors and patients with various levels of mutual understanding, conflict, cooperation, authority and subordination jointly construct or co-construct the medical visit as a real-time interactional product and therefore share responsibility in the communicative process and the outcomes (Heritage & Maynard 2006:19). Others have indicated that the medical interview should be analysed from an approach that integrates the physician-centred and the patient-centred approaches (Michie, Miles & Weinman 2003; Oates, Weston & Jordan 2000). This would reconcile the two agendas (Levenstein et al. 1989, cited in Ong et al. 1995: 904)) or display mutuality (Roter & Hall 1992). Proponents of such an approach described the doctor-patient relationship as a partnership (Starr 1982, cited in Potter & McKinlay 2005: 467). The intention behind the use of an integrative approach is to let the patient lead the interaction in his/her areas of expertise (symptoms, concerns, preferences) and the doctor in his/hers (details of disease and treatment). The three functions of the medical consultations mentioned earlier enable the doctor to gather information about the patient's health, educate him/her about the prescribed treatment options and explore the emotional and social issues

that may influence the health outcome (Bensing 1991). At the same time the patient is given the opportunity to participate in the process. The integrative approach is more appropriate to the investigation of the HIV/AIDS consultations in the present study.

Cordella (2004) also supports the integrative approach by pointing out that although people may come from different cultural backgrounds they are all potential patients that will sooner or later be faced with the need to communicate with a health worker. She indicates that the socio-cultural perception people have of their illness may influence the manner in which they talk about it with the doctor. In this regard, Cordella's (2004) work is significant in that it aims at identifying aspects of talk that are problematic because of the socio-cultural and multilingual background of interactants, so as to give them special attention in order to improve communication. As indicated earlier both interlocutors work together because the doctors need information to establish the right diagnosis and treatment plan while patients need to know what their problem is as well as meet the need to "feel known and understood" (Ong et al. 1995: 904). This resonates with the explanatory model (EM) which is defined as, "the notions about an episode of sickness and its treatments that are employed by all those engaged in the clinical process" (Schouten & Meeuwesen 2006: 29). The patient's expertise is appreciated and recognised as an aspect of good doctor-patient communication i.e. the intelligible exchange of information and the mutual recognition of the most appropriate way to participate in the exchange. Since both interactants hold different EMs, they offer explanations of episodes of sickness and appropriate treatments. The quality of this communication then may be the key to assessing and managing the problem successfully and is vital for effective treatment, compliance and hopefully a return to health. Doctor-patient communication has also been studied from a medical perspective that reflects a sociological bearing which emphasises ways in which communication can promote patient satisfaction and lead to better outcomes and ultimately lead to recovery (Ong et al. 1995).

Again with the notion of integrating approaches, Cordella (2004) conceptualises the doctor-patient communication as a dynamic process and analyses the participation of both interactants at the micro and the macro levels, to investigate and show how their discourse sequences and forms of talk may hinder or enhance their understanding and co-operation. She describes the various discourse forms used by doctors and patients in the medical consultation as different kinds of voices that are specific to their specific contexts such as the particular institution in which the study is carried out. She thus offers an interaction model which can be adapted and modified widely to minimise the tensions between the traditional disease-centred approaches of bio-medical practitioners and the holistic expectations of their patients; and to widen the scope of discourse analytic studies aimed at

facilitating doctor-patient communication. This approach is relevant to the present study but rather than conceptualising the consultation as different voices, my study explores the doctor-patient interactions during the HIV/AIDS consultations purely from a linguistic perspective. My study resonates with the post-structuralist perception of discourse in that it indicates how different cultural contexts and situations impact on interaction.

With the growing perception that studies encouraging partnership relationship between doctors and patients are 'better' than those emphasising the dominant role of the doctor or those emphasising the bio-medical aspect, there is now a paradigm shift to approaches that incorporate the patient's perspective into a relationship-centred medical model of communication. The present study has been greatly influenced by the complementary nature of integrative approaches and the fact that such approaches widen the scope of the analysis. I have therefore adapted it by merging discourse and conversation analytical tools to explore the discursive and linguistic features of doctor-patient communication as the interactants who come from different linguistic backgrounds and possess unequal linguistic competences co-construct the HIV/AIDS consultation in ELF.

3.3. Theoretical points of departure of the study

The following section identifies the approaches that constitute the theoretical framework for the analysis in this study, namely: CA (see Schegloff 2001; Liddicoat 2007), DA (see Stubbs 1983; Cook 1989) and genre theory (Bhatia 1993, 2004; Halmari & Virtanen 2005). DA and CA have been found to be particularly insightful in analysing and describing naturally occurring talk (see Schegloff 2001; Schiffrin, Tannen & Hamilton 2001). Sections 3.3.1, 3.3.2 highlight the linguistic and discursive features that these theories seek to explore, while section 3.3.3 gives an exposition of genre theory. DA and CA are distinct theories that explore different aspects of language use in different disciplines. However, there is some overlap because they both have an interest in discourse, thus larger units of spoken or written text, as a basis for analysis and sometimes explore the same issues albeit with varying instruments (Brown et al. 2006). While DA enables the researcher to explore the macro contextual aspects of the medical consultation, CA focuses on the specific elements of conversational structure as they are embodied in lexical syntactic and communicative features. The line between these theories is not clear-cut because they are both used to study discourse in general and interpersonal interaction between doctors and patients even though each focuses on different aspects. Medical discourse and doctor-patient consultations are examples of discourse that can be analysed and interpreted from different, complementary perspectives using CA and DA.

3.3.1 Conversation analysis (CA)

The fact that CA and DA both deal with issues of discourse and communication that overlap makes it tricky to put a clear-cut boundary between the two, nevertheless, each emphasises specific aspects of the communicative events (Brown et al. 2006). Some research suggest that CA should be included under the general heading of DA (see McCarthy 1991; Brown et al. 2006). Like DA, CA has offered a theoretical and methodological foundation for documenting the interactional construction of social orders to a broad interdisciplinary community with an interest in language use. Disciplines that use CA in their analytic endeavours include Linguistics, Sociology, Anthropology, and Psychology (Lerner 2004). The social order here refers to the order created jointly, contingently and locally by participants in talk-in-interaction (Ford, Fox & Thompson 2002). The following discussion provides background to CA and discusses the thrust of DA and CA, highlighting the fact that they are both used as instruments of linguistic inquiry.

Many studies agree that the expression 'Conversation Analysis' was initially used widely to denote any study of people talking together, but then also in a restricted sense to denote a tradition of analytic work begun by Sacks and his collaborators Schegloff and Jefferson in the 1970s (Ten Have 1999, 2004; Lerner 2004; Heritage & Maynard 2006; Sidnell 2010). However, it was Garfunkel who is reported to have been the major force in the emergence of CA as a specific style of social analysis, when he developed the research concept called ethnomethodology in 1967 (Lerner 2004: 25). This is an approach that focuses on the study of common-sense reasoning and practical theorising in everyday activities. In other words, the ethno-methodologists set out to discover what methods people use to participate in and make sense of interaction especially in face-to-face interactions like the consultations in the present study.

Sacks' direct confrontation with tape recordings of telephone calls to the Centre for Scientific Study of Suicide in Los Angeles in 1963-64, developed what was later known as CA (Ten Have 1999; Liddicoat 2007). It took intense intellectual interest in the details of the actual practices of people in interaction, like the doctors and patients in the present study. By 1975, CA was already an established paradigm and from an originally non-linguistic perspective, it was developed as a theory and method to account in a detailed, data-driven manner for the resources and practices used in creating social orders through situated language use (Ford, Fox, & Thompson 2002). Schegloff (1987, 1992) and most recently, Sidnell (2010), acknowledge that CA started as an analytic approach in Sociology and later developed into an area of research in its own right, which can handle all kinds of talk-in-interaction. Initially CA researchers focused on describing the

organisational structure of mundane, minimally planned, everyday conversation (i.e. casual, social talk), that routinely occurs between friends and acquaintances, either face-to-face or on the telephone, focusing on sequences, turn-taking and repair practices. Eventually, the use of CA was extended to other aspects of participants' talk-in-interaction such as silences, overlapping talk, sound stretches, and breathing (Markee 2000; Schegloff 2001). Most of these features do not constitute the primary focus of this research and so will not be discussed. My interest is in investigating the linguistic and discursive features that characterise this type of cross-cultural communication to see what linguistic resources are employed to resolve misunderstandings.

The bedrock of CA is sequencing which works on the premise that social actors do not just follow externally, imposed rules, but that they are always actively creating order through their own behaviour (Ochs, Schegloff & Thompson 1996). This approach sees conversation as one of the ways in which participants create social order, and so bases its analysis on the sequential organisation of talk focusing on aspects of interaction such as turn-taking, sequences and repair (Mazeland 2006). CA has shown that there are no aspects of interaction that are disorderly or insignificant noise (Heritage & Maynard 2006). It does not lay emphasis on building structural models from the outside, but on close observation of the behaviour of participants in talk and on patterns that recur over a wide range of natural data. Analyses that follow this approach strictly proceed from bottom-up, trying to establish the smallest units of interaction first and avoiding "over-hasty premature formalisation" (Levinson 1983: 287, cited in Cook 1989: 52). The interest of this approach is not to wait and analyse the discourse when it is complete but rather to understand it as it unfolds in time bearing in mind that discourse is a developing process and not a finished product. Seen from this perspective the smaller units ultimately develop into the rank structure in the analysis of discourse and the audio-recorded data gives the researcher the opportunity to analyse the interaction as it unfolds as well as see it as a finished product through the transcriptions.

Most of the material that Sacks initially used was based on data collected in institutional settings such as suicide calls at the centre in which he worked (Sacks & Jefferson 1992; Lerner 2004). Along with other collaborators, he later turned to the analysis of conversations in other settings because these provided better examples of the functioning of conversational devices and interactional formats such as "turn-takings" and "opening up closings" (Ten Have 1999: 8). Thus CA developed from a narrower interest, until later adherents to CA turned their attention to institution-based material such as meetings, courtroom proceedings, and interviews, aiming to apply the acquired knowledge of conversational organisation to the discourse in these contexts. CA findings and methods show a particular promise for providing a strong empirical framework for

accounts of linguistic structures in discourse (Ford et al. 2002). The present study follows in their sway as it investigates the linguistic features of HIV/AIDS discourse.

3.3.1.1 Conversational features used in CA: turns, repair and sequences

The following section focuses on the different conversational features (turns, repair and sequences) which have characterised and are instrumental in CA and which have been explored in the present study. Although all conversational features are relevant to the study, not all are investigated specifically because the present study covers only the linguistic patterns and mechanisms verbally displayed in doctor-patient interaction during HIV/AIDS consultations in ELF. Verbal strategies that interlocutors use to resolve misunderstanding in the intercultural context, are also given attention.

i) Turns and turn allocation techniques

A 'turn' is constructed out of smaller turn construction units (TCUs) and has been defined as "one or more streams of speech bounded by the speech of another, usually an interlocutor" (Crookes 1990: 185, cited in Markee 2000: 83). This definition recognises a turn as a structured part of an interactional activity between participants but does not give a complete picture of the scope of the term since it does not account for the substantial amount of overlapping talk. It does, however, introduce, the issue of projectability of cues involved in talk as people have to determine anew after each turn and project roughly when the speaker might complete the next turn. However, the occurrence of overlap especially from more than one interactant in an interaction with multiple interlocutors requires a more comprehensive definition of the 'turn' because projecting the completion point of a speaker's turn does not mean that he/she has stopped; neither does it stop him/her from continuing. Thus, the definition of a turn as "a spate of talk that is collaboratively constructed by speakers out of one or more TCUs whose projectability allows possible next and current speakers to identify when current speaker's turn might hearably be coming to an end" (Markee 2000: 84).

A 'turn' is a basic feature of conversation and so it is important to understand the allocation techniques that are used to negotiate turns in any interaction. It is important to note that culture, purpose and the audience specify rules and procedures of turn-taking such as entering and leaving conversation, bidding for a longer turn, refusing to take the floor without appearing rude or changing the topic. Differences in language structure can lead to the deployment of different

grammatical practices for interactional organisation of turns. For example, Mazeland (2006) discusses the difference between English and Japanese which has a subject-object-verb and object-subject-verb word order and points out that the strict subject-verb-object-word order in English allows for early projectability of the design of TCUs because of the early positioning of predicates Mazeland (2006: 156). All of these differences provide ample ground for misunderstanding and a real problem in second language and lingua franca interactions.

In CA terminology, TCUs may consist of sentential, clausal, phrasal or lexical objects (Sacks, Schegloff and Jefferson 1974; Markee 2000; Mazeland 2006). Speakers and hearers use their knowledge of sentence-syntax level to project the possible completion point of a turn, and then determine when they can appropriately start their own talk. The intention is to allow each interactant the opportunity to hold the floor and talk uninterrupted. However, this is not always accurately done sometimes because of poor timing or a need to clarify something that has just been said. This may result in overlaps in talk-in-interaction in the form of collaborative offers of help where one then finds affiliating utterances as TCU completion (Lerner 2004), competitive interruptions or overlap of some particular significance such as signalling annoyance, urgency, or a mere desire to correct what is said (Cook 1989). Cook notes that pauses, laughter, intonations, and filler words between turns carry particular meaning of marking the direction the participants are taking. It would be interesting to look out for some of these features and to understand what role they play in turn-taking and sequential patterns in the HIV/AIDS consultations of the present study. It must be noted that non-linguistic factors like eye contact, body movement and position as well as intonation and volume contribute to turn-taking. But since the primary data for the study is an audio recording these non-verbal aspects of the interaction will not be investigated because they can only be observed through participant observation and/or video recording.

Sacks, Schegloff and Jefferson (1974) highlighted two main techniques of turn allocation in different communication genres such as debates, press conferences, plays, therapy sessions and especially ordinary conversation. They are:

i. One speaker speaks at a time, though there is a possibility of simultaneous speech; and
ii. Speaker change recurs: The floor is not given to any one speaker for the duration nor is it parcelled out in advance. Rather the floor is constantly negotiated and renegotiated.

These techniques are still applicable and operational in the organisation of interaction, even today, and are the basis of CA investigation. The important question here is how this negotiation is managed to achieve an outcome which is communicatively most effective. At the end of each turn, a set of rules sets in at a point called ‘turn transition relevance place’ to determine who takes the

next turn (Markee 2000; Boxer 2002; Lerner 2004; Mazeland 2006). These rules can be summarised in three main rules as follows:

i. Current speaker selects next speaker;
ii. Next speaker self-selects or failing this;
iii. Current speaker may continue. (Lerner 2004: 38)

He elaborates on the rules as follows:

i. If a current-speaker-selects-next-speaker technique is used, then the party thus selected has the rights to, and is obliged to take next turn to speak and all others are excluded;
ii. If a current-speaker-selects-next-speaker technique is used, then on the next possible completion of the sentence current speaker is constructing, transition should occur i.e. current speaker should stop and next speaker should start;
iii. If by any possible completion of the current sentence of a turn, current-speaker-selection of a next has not been done, self-selection may, but need not be instituted, with first start acquiring rights to a turn at talk; and
iv. On any possible completion of some current sentence, current speaker may stop, but unless he has done selection, he need not stop unless another has self-selected. (Lerner 2004: 38)

There are alternatives to this mode of operation in some genres. For example, in debates the ordering of all turns is pre-allocated by reference to the 'pro' and 'con' positions, in meetings there is a chair-person presiding over, who has the right to speak after each speaker and who can use his/her turn to allocate next-speakership (Lerner (2004: 36). He proposes a linear array in which one polar type involves one-speaker-at-a-time and the other pole involving pre-allocation of all turns, and then a medial type that mixes local and pre-allocation modes. He further suggests that all turn-taking systems each specify turn-taking differently. For all positions, turns are organised in different discourse genres via language. Turn size correlates with position on the linear array, increasing from conversation through meetings to debates. The organisation of one-party-talking-at-a-time is primary to communication, and turn allocation and turn-constructional techniques provide for just one next speaker and for a minimisation of both gaps and overlaps between turns (Lerner 2004; Mazeland 2006). However, this is not always achieved because conversational rules are often flouted (Grice 1975). A flout may occur when a speaker fails to observe a maxim at the level of what is said with the intention of generating an implicature. This can in turn affect the turn-taking and sequential patterns in an interaction. Turn-taking practices in equal and unequal power speech exchange systems are modified by the roles and position of the interactants (Markee 2000). An example of this is the classroom discourse in which the teacher as the powerful interlocutor exerts control over the learners (see McHoul 1994). The doctor-patient consultations in the present study

fall in this group as they present conversational procedures used by doctors (the powerful interlocutor in terms of authority) and the patients (the vulnerable partner) to negotiate turns during HIV/AIDS consultations to see if the participants adhere to the conversational rules outlined above.

ii) Repair strategies

This is another aspect of language use on which CA focuses. Repair refers to a vast set of practices for dealing with troubles that arise in the course of speaking, hearing and understanding talk-in-interaction (Ford et al. 2002). From a CA perspective, all repairs are likely to be signalled by various markers that are incipient of repair such as pauses, silences, sound stretches, cut-offs and phrases like "you know" and "I mean" (Markee 2000: 102). Repair is dependent on members orienting to the turn-taking procedures that constitute a particular speech exchange system. This can be an independent form of conversational organisation that is analysable in terms of distinctive sequential trajectories which include:

i. Its position in relation to an initial trouble source;
ii. Who initiates and completes it i.e. either 'self' (current speaker) or 'other' (interlocutor);
iii. Whether a repair is successful or unsuccessful (Schegloff et al. 1977, cited in Markee 2000: 102)

Repair can occur in four positions: the first and third position repairs that are initiated by 'self' following the occurrence of a trouble source, and the second and fourth position repairs that are 'other'-initiated (Markee 2000: 102). Repairs initiated from all these positions are typically completed by self, and sometimes by other. The manner in which a repair is initiated can give an initial, on-the-spot indication of which part of the turn will be operated on by the repair (Ford et al. 2002). This resonates with the view that practices of same-turn repair specifically deal with troubles as they arise in the course of the current speaker's ongoing turn, that is first position repair since "they are placed within the same turn as the trouble source" (Markee 2000: 102). Same-turn repairs stand as a resource for changing the content of an utterance by correcting, enhancing and abandoning the turn, but are a resource for presenting speakers and recipients in interactionally significant ways (Ford et al. 2002). But 'cut-off' and instances of 'uhmm', tend to be positioned differently with respect to the turn's trouble source. 'Uhmm' commonly initiates repair on projected talk that has yet to be produced while cut-off, initiates trouble with the turn-so-far, trouble with the whole turn produced to that point or trouble with some element thereof (Ford et al. 2002). The present study is interested in investigating the use of repair as a linguistic feature in HIV/AIDS discourses in a cross-cultural setting in which English is a lingua franca.

iii) Sequences structure

Sequences and turns are ultimately intertwined even though they are different. A sequence is viewed as a dynamic matrix of activity whose organisation involves two or more individuals in a focused manner (Ford et al. 2002). The interactants in the present study can be said to produce sequences during the consultation since in each case there are at least two people involved in a much focussed manner. Sequences have been defined elsewhere as "an ordered series of turns through which participants accomplish and co-ordinate an interactional activity" (Mazeland 2006: 156), a reason why they are understood as a coherent episode. Sequences comprise of turns deployed as actions that follow a particular order. These turns in themselves reveal an obvious and yet complex temporal and progressive ordering in interaction. For instance, the production of a turn involves an ordered progression of a verbally structured action, and the operation of turn-taking depends on an ordering of speaking opportunities that are present in a sequence. This is understandable because certain actions are treated as relevant only after other actions in the same way as some utterances can only logically follow after others and be understood as such. This is why CA analysts have documented specific sequence types at specific points in an interaction, for example the greeting and closing sequences. The greeting sequence is characterised by adjacency pairs of questions and answers or requests and the decisions that are made about them at a given point in time in the interaction (Mazeland 2006; McCarthy 1991). Certain turn specification types are relevant at specific recognisably unfolding sequence types, showing that they are tied to the sequences in which they are deployed (Ford et al. 2002). Thus a 'good bye' would be found only in a closing sequence and 'hello' in the greeting or opening sequence. Other types of sequences are the insertion and side sequences. In the insertion sequence a question and answer pair contains another question and its subject is intimately related to that of the main sequence. But in a situation where the speaker switches from one topic to an unrelated one before returning to the main topic, that constitutes a side sequence. All of these sequences are possibilities in the present study.

3.3.1.2 Strengths and limitations of CA

One of the strengths of CA is that it provides a research and an analytical approach that has a wide scope of application in various disciplines such as in Sociology, Psychology and Linguistics, each relating to different dimensions of the approach. For example, there is a dimension of CA that some researchers call Discourse Functional Linguistics (Ford et al. 2002), which deals with data that document the interactional nature of language use in face-to-face conversation: this makes use of new technologies such as video tapes. Other researchers such as Goodwin and Heath have extended

the scope of CA to include visual aspects of interaction such as bodily comportments (like gaze shifts), manipulation of objects, the reading of screens and typing on keyboards (Ten Have 2002: 3). However, despite the likely benefits of using video recordings in the particular context of my research, it was found to be too intrusive, and problematic in terms of ethical considerations. Therefore this study made use only of audio-recordings.

Some conversation analysts (Mehan 1993; Cicourel 1992, cited in Markee 2000) have incorporated ethnographic information into their analyses, claiming that such information is necessary for a complete understanding of talk-in-interaction. From a 'purist' perspective of CA context means the immediate sequential environment of a turn, the environment which discourse analysts call co-text of talk that provides participants with a metric with which to judge the appropriateness of the talk produced in the next turn (Markee 2000: 28). This implies that CA does not use data unless there is internal evidence in the discourse to warrant its introduction for instance the mention of one participant's race or gender. This is why it has been criticised for its apparent avoidance of social analysis and critique and its lack of consideration of context (van Dijk 1999). Context is particularly important when studying institutional interactions because of the influence of orientations and constraints specific to an institution which affects the conduct of the participants, the organisation of their activities and their local identities. But CA's specific focus on the local organisation of talk-in-interaction makes it difficult to determine what variables of the socio-cultural context must be considered (Ten Have 2004: 18). In such a situation the researcher uses his/her discretion to decide what is relevant to his/her study.

The CA approach is distinct in its goal of basing its observations, claims and generalisations on close analysis of specific cases of naturally occurring talk like the HIV/AIDS consultations in inter-cultural contexts like the clinics in the present study. In this way, Conversation Analysts do not develop arguments about the structure of conversation based on quantitative analyses of frequency of data since such analyses cannot reveal much about how participants orient to the underlying structure of conversation but through universal interactional resources for making meaning they demonstrate the nature of conversation (Markee 2000; Ten Have 2004). This is why CA is able to draw conclusions from which generalisations can be made based on single instances of particular phenomena that attest to the nature of the interaction in real life. However, these generalisations while presented as strong claims for particular data sets like those presented in the present study, have been said to be taken as provisional, testable and revisable as further empirical research with new data could provide convergent or divergent cases (Ford et al. 2002).

One reason why conversation analysts avoid considering how attributes like race, class, gender affect conversational transaction is because it prefers to attend first to the detail that is involved in the orderly achievement of mutual understanding through the linguistic interaction, rather than additional circumstantial facts and abstractions these may generate (Heritage & Maynard 2006). This may explain why researchers of the 'purist' CA model are opposed to using socio-economic status, gender, biographies and ethnographic data to explain how members organise and make sense of the talk they construct for each other (Markee 2000). It is important to note that communication is done in words and through other means such as shared knowledge, tone and intonation, context and cues (Andersen 1999). Considering the fact that conversation does not exist in a social vacuum these social variables, even though they are ethnographic in nature, can to some extent constitute the co-text in any discourse and so can be considered in CA. The present research however, will take a compromise stand on this controversy, considering some aspects of the socio-cultural context as well as linguistic and discursive features that characterise the doctor-patient consultations during HIV/AIDS consultations. This is motivated by the insight that the patient's life world and experiences are not left outside the doctor's consultation room, but may "leak" into it (Heritage & Maynard 2006: 6).

Some CA analysts hold the opinion that linguistic analysis should be concerned with reflexivity and the search for logical practice without the observer and researcher objectifying the participant's behaviour and meanings (Prevignano & Thibault 2003). This is an echo of the 'purist' paradigm of CA which pays attention to the detail in, rather than outside talk and focuses on the sequential organisation of what is actually said in the interaction such as turn-taking and the distribution of speaking rights in relation to the institutional functioning (Ten Have 1999: 8). Thus the raw data from everyday conversations such as the HIV/AIDS consultations in this study can be analysed to show that speakers observe certain rules which establish patterns and order in the way they talk. In this way, it is possible to investigate and make statements about naturally occurring talk on the basis of evidence from the text or recorded conversations like the consultations in the present study. This implies that from a purist perspective, what participants in a conversation say provides enough information for a complete analysis of the text or discourse to be carried out. It is on this premise that I believe that the audio-recordings of the doctor-patient interactions during the HIV/AIDS consultations would provide information regarding the linguistic features that characterise this form of interaction in the context of the clinics.

Researchers that have used the CA approach for doctor-patient interactions include Frankel (1984, 1990), Heath (1984, 1986, 1988, 1989 & 1992) and Ten Have (1987, 1989, 1990, 1991, 1993 &

1995), all cited in (Ten Have 2002: 3). Their work has focused on medical consultations in the context of general practice or family medicine. None of these studies has investigated linguistic or discursive features in HIV/AIDS consultations or investigated how possible misunderstandings are resolved during such communication in a situation in which a lingua franca like English is used.

3.3.2 Discourse analysis (DA)

The appellation Discourse Analysis is a very ambiguous one given the wide range of its application in various disciplines. Following from the different conceptualisations of 'discourse' (Section 3.2 above), a corresponding range of definitions of DA emerges. DA is an interdisciplinary activity that builds on frameworks developed and established in sociolinguistics, philosophical linguistics, psycholinguistics, computational linguistics and anthropology, as well as descriptive and applied linguistics (Hymes 1972; Brown & Yule 1986; McCarthy 1991). It is used in psycholinguistics to deal with issues relating to language comprehension, while in philosophical linguistics it is used to analyse semantic relationships between constructed pairs of sentences and their syntactic realisation. In Sociolinguistics, discourse has patterns which reflect ways in which people use language to communicate either in writing or in speech (Gee 2008). These patterns reflect particular realities in different cultures. From this perspective therefore, DA considers 'discourse' as "stretches of language which 'hang together' so as to make sense to some community of people" (Gee 2008: 82). This implies that sense making is a social and variable matter because what makes sense to one community may not make sense to another. So to understand sense making it is necessary to understand how language is embedded in society and social institutions such as the HIV/AIDS clinics in the present study (Gee 2008: 115). DA also interests language teachers especially when they design teaching material or engage learners in exercises and activities aimed at making them proficient users of a target language (Cook 1989). DA has thus been conceptualised as a way of describing and understanding how language is used (McCarthy 1991).

From a linguistic perspective, DA refers to a methodological approach to the study of the organisation of units of language larger than the sentence, and of naturally occurring connected spoken language, such as written texts or conversational exchanges which use linguistic strategies that create cohesion between the various constituents (Stubbs 1983; McCarthy 1991; Potter & McKinlay 2005). DA has been defined in terms of the nature of its focus and point out that "discourse analysis focuses on the jointly constructed process of interaction as it pays attention to the multifunctional, context-specific nature of language use" (Finlay & Sarangi 2006, cited in Brown et al. 2006: 668). This definition is most relevant to the understanding of DA in the present

study and forms the thrust of the discussion as the data comprise of conversational exchanges of naturally occurring discourse (the consultation) ranging from single words to extended sequences.

From a sociolinguistic perspective, DA focuses on the investigation of language varieties and the effect of the different contexts on the way language is used i.e. it considers all aspects of society that underlie the development of different language varieties, dialects and sociolects. Sociolinguistics studies the variation of dialects across cultures and social variables such as ethnicity, gender, social class, education, and religion to name just these (see Fishman, Cooper & Conrad 1977; Bamgbose & Banjo 1995; Crystal 2003). Although the present study does not dwell on the differences in the varieties of English in South Africa, it focuses on the English second language (ESL) users who have become the ELF speakers and whose L2 is also the local lingua franca. Thus ELF speakers, use various L2 varieties that are in many ways different from Native speakers' English (NSE) during routine HIV/AIDS consultations in face-to-face interactions (Boxer 2002). The study therefore examines the linguistic characteristics and communicative dynamic involved in the use of ELF in a multilingual medical context, particularly as it is used in the treatment of HIV/AIDS, as one of the medical conditions that rely heavily on a particular level of communicative success in consultations.

Health science research uses a stream of DA that defines discourse as a concept that refers to broad systems and institutions that recreate power relations (Powers 2001, cited in Nixon & Charmaine 2007: 72). The asymmetry in the power dynamics in doctors' and patients' communication, especially in consultations has been attributed to the institutional setting and has been widely documented (see Beisecker 1990; Ainsworth-Vaughn 1998, 2003; Heritage & Maynard 2006). Such interactions have generally been agreed to be asymmetrical due partly to the institutional settings in which they occur and partly because they are viewed from the premise that the doctors operate from a position of knowledge which they are required to have. Thus they do have a particular kind of power in health matters. This is why some studies have shown that doctors often worry about the effectiveness of their communicative skills and about how well the patients understand and use the information given to them (Ammerman, Perrili, Alder & Irwin 1992; Ong et al. 1995). Such concerns of the physician are intensified when the communication is taking place in a language in which one or both parties have limited competence the language as it is the case with ELF in this study. Critical Discourse Analysis (CDA) is an analytic approach that is distinct from DA, and is typically used where power asymmetry appears to be particularly prevalent and most likely also in need of redress (as e.g. in public discourse between government and a parent representative body in a school district). But since the power asymmetry in the consultation context

is of a different kind, it is not the main focus of this study. Asymmetry in power relations will be discussed only when the organisation of linguistic features such as turns and sequences reflect the directive power of the physician.

Post-structuralist DA discusses historical and genealogical changes in discourse, emphasising the emergence of new discourse emanating from the decline of the old (Hall 1997; Nixon & Charmaine 2007). This gives an indication of the shifts in the different approaches used in medical discourse analysis; it also gives insight into how perceptions of illness and a disease such as HIV/AIDS are reflected in discourse over the years. But since this study is not investigating these issues the shift in attitudes towards HIV/AIDS is only discussed when expressly mentioned in the consultation. Social constructionist DA as represented in the work of Fishman (1971) focuses on analysing language as a social and cultural practice (Nixon & Charmaine 2007: 72) and is relevant to the present study because consultations are a form of interaction and an aspect of culture and socialisation.

There are many dimensions of DA (Wetherell, Taylor & Yates 2002). These have recently been characterised across the following four axes (Traynor 2006: 63-64):

i. "Identifying codes" (attending primarily to language properties and linguistics features): This approach focuses on the structure and properties of language and has a more positivist understanding of mechanisms of communication between humans as unified subjects.
ii. "Use and interaction" (as investigated in CA and Ethnomethodology): This approach foregrounds language with the understanding that speakers communicate in a social context in which conventional conversational practices constrain them.
iii. "Interpretive repertoires" (as in studies of occupational communication): This approach focuses on talk in interaction, analysing how individuals maintain their membership in occupational groups. It analyses language in social and cultural contexts moving along the theoretical continuum to a post-structuralist underpinning where "language is the material enactment of social, political and philosophical structures and forces" (Nixon & Charmaine 2007: 73).
iv. "Societal discursive practices" (as in studies of discourse and power): This approach identifies patterns of language use and related practices. It examines how they constitute aspects of society and the people in it. This approach also includes CDA and Foucauldian DA in which "the human subject is made possible by discourse" (Traynor 2006, cited in Nixon & Charmaine 2007: 73).

It is evident from this categorisation that the common interest shared by all of the disciplines that feed into DA, is the analysis of language in use, that is, how real people use real language. This

study investigates exactly such authentic use of language (as opposed to studying experimentally designed utterances, or stimulated responses). The identification of codes and language use in interaction (i and ii above respectively) resonate with the objectives of this study as I investigate the structure and properties of the language used in HIV/AIDS consultation, and also highlight the fact that the speakers communicate in a social context that imposes some constraints on them. Bearing in mind the multilayered dimensions of DA approaches to discourse, DA is a study of linguistic forms and the regularities of their distribution as well as a consideration of the general principles of interpretation by which interactants normally make sense of what they hear or write (Brown & Yule 1986).

3.3.2.1 Shortcomings of DA

The DA approach considers largely the textual, contextual and formal linguistic features of discourse, with primary attention to how coherence and cohesion are established. Communication consists of verbal (segmental), non-verbal (supra-segmental), and contextual features that may all be significant and thus need to be attended to. But DA relies on transcription conventions developed in a 'neighbouring' field, notably in CA. A complete analysis of any discourse has to consider these non-verbal, multimodal features as well as the social context in which the discourse is taking place. Thus, the DA approach has not developed its own set of conventions for representing the paralinguistic features of an utterance such as 'voice quality'. It does not distinguish between saying something kindly, harshly and loudly (Brown & Yule 1986). This indicates that there are problems representing the segmental record of the spoken word, and that representing supra-segmental features such as intonation and rhythm is even more complex. Therefore, even conventional transcription symbols such as the use of capital letters and underlining do not adequately capture aspects like loudness or emphasis which they may be meant to do.

Customarily, in DA the analyst does not relate discursive details to indexical features such as the speaker's approximate age, sex, educational level, personality and state of health to the voice or temporal features of speech, such as pace of speech and the tendency for certain words to be grouped more closely together (Brown & Yule 1986). Where this information has a perceivable bearing on the interaction, and will give clarity, DA has to find a way of eliciting such information and introducing it in the analysis.

A disadvantage of this approach could be the tendency to over-analyse the data, especially when critical attention is focused on details of spoken language, which the speaker might have considered

unimportant. This might skew the findings according to the subjective interpretation of the analyst. Knowledge and recognition of the limitations of DA as an analytic approach generally, and as an approach that may distinguish ELF-features specifically, is important because it checks the researcher against 'over-interpreting' particular features of the consultations. The fact that this study will not investigate the supra-segmental features that possibly enhance this form of discourse, allows the researcher the latitude to ignore complications that such features may entail. The result is that the analysis admittedly does not give a complete picture of the interaction, since the data captures only what the interactants verbalise and not the full range of non-verbal communicative devices that were also used.

3.3.3 Genre Analysis

This section focuses on genre theory with the aim of showing that HIV/AIDS consultations constitute part of the medical discourse genre. Here, I define 'genre' and discuss its dynamic nature and conceptualise consultation as a text type in medical discourse to establish its relevance to oral genres that are identified in the HIV/AIDS consultations in this research. I then discuss the strengths and weaknesses of genre theory and genre classification as it highlights the notions of genre-mixing.

3.3.3.1 Definition and description of genre

Genre studies offer different perspectives from which discourse can be analysed ranging from those that give a textual and linguistic description emphasising specific choices of lexico-grammar and discursive structures to those presenting ethnographic accounts of critical moments in research sites (Swales 1990: 33). The contexts in which genre features are explored are varied as they could be institutional, professional or organisational. The interest of genre research is in revealing how certain genres are characteristic of given cultures, their aims, objectives and constraints. A particular challenge in genre studies arises from the fact that as times are changing, generic features also change resulting in instability of generic integrity due to hybridity in terms of textual realisation and modes of presentation (Swales 1990: 49). As a result, the idea of clearly demarcating and closely attaching certain genres to particular communities of practice is difficult to maintain (Bhatia 1993, 2004; Swales 2004; Halmari & Virtanen 2005). This is because social pressures and the changes in the institutional, professional and organisational structures of certain communities of practice have blurred boundaries. Thus one field of practice can borrow the key generic characteristics of a genre typically used in another, for its own purposes. This results in

genre mixing and hybridity. This introduces the idea of genre variation and dynamism which are a result of intertextuality and interdiscursivity. These aspects reveal a shift from the pedagogic orientation on genre which was concerned with the teaching of foreign languages for specific purposes (where generic rules were rigidly taught) as discussed in these studies, towards one with new audiences, experimenting with genres in their social and institutional space. I shall return to this in Chapter 5, section 5.4 where I indicate how the interactants in the HIV/AIDS clinics draw on generic features of one kind of discourse in taking part in a discourse of a different kind. But first, I define genre and genre analysis with the aim of establishing their relevance to the present study.

A genre is defined in the Webster's New International Dictionary of the English Language as "a category of artistic composition or a category of things distinguished by some common characteristic or quality as in music or literature, marked by a distinctive style, form, or content" (Neilson, Knott, & Carhart 2009: 1046). It is a term often used to categorise units of literature and speech but is also used to identify characterising features of any other form of art or utterance. It can be described as a way of speaking or writing that people learn to mimic, weave together, and manipulate, for example, writing a formal letter, making a grocery list, or giving a university lecture (Fairclough 2003:7). Thus, genres are sometimes socially specified as they are recognised and defined by a particular culture or community. A sociolinguist like Fairclough conceives of 'genre' as a form of expression that emphasises the social context of the text and he buttresses this point when he observes that genres are "different ways of (inter)acting discoursally" (Fairclough 2003: 26). He finds that the notion of genre highlights aspects such as the purpose of interaction, features of layout and the language used to reflect these purposes. Others have pointed out that, what fundamentally defines genre is the recognition of its communicative purposes (Halmari & Virtanen 2005). A genre can then be conceptualised as a class of communicative events, with a common set of communicative goals shared by members of a given discourse community, for example, meetings, debates, conferences and in the case of the present study, consultations.

The role of linking the communicative purpose of interaction to the genre, tasks and goals of the discourse community has been one of the foci of genre analysis. This perspective is held by researchers who believe that genres acquire a label and vocabulary of their own which the discourse community makes use of and therefore has expertise in the area to which this particular genre belongs (e.g. Swales 1991, 2004). This implies that genres do not belong to individuals but are the properties of the discourse community (Swales 1990: 34). This is the reason that he conceptualised discourse communities, described as "socio-rhetorical networks that form in order to work toward sets of common goals" (Piqué-Angordans & Posteguillo 2006: 650). Established members of these

discourse communities are expected to be familiar with the particular genres that are used in the communicative furtherance of those sets of goals. It follows then that any discourse community knows the intended audience and purpose of any particular genre that is used at a particular time and context although as mentioned earlier this demarcation of the genres is not always clear cut. This implies that the goals motivating the existence of a genre are determined by the discourse community and these goals influence the discursive strategies that are typically adopted and hence the form and content of the text produced. From this perspective, HIV/AIDS consultations are considered as part of the sub-genre 'consultations', which in itself is part of the medical discourse genre and the participants belong to this medical discourse community. The patients and their doctors can be said to belong to the medical discourse community that furthers the goals of HIV testing, treatment of opportunistic infections and follow-up of ARV treatment through consultation.

Genre analysis has been defined as "the study of situated linguistic behaviour in institutionalised academic or professional settings" albeit from different orientations (Bhatia 2004: 22). For example, he alludes to Mishler (1984)'s definition of genre in terms of typification of rhetorical action, regularities of staged, goal-oriented social processes or consistency of communicative purposes which has been highlighted in other studies (Swales 1990; Bhatia 2004; Halmari &Virtanen 2005). He points out that this view of language use in institutionalised and professional settings emphasises conventions that are central to the description of genres. Some analyses explore features such as the contextualisation of discourse where aspects such as purpose, practices and the players in the discourse are investigated, while others investigate the organisation of discourse and focus on how patterns of discourse are organised. This indicates that the goals of genre analysis are many and varied depending on the orientation of the study. But although the discussion presents different orientations to genre analysis in some of these studies, not all of them are relevant to the present study whose focus is on the communicative features of the HIV/AIDS consultation between doctors and patients.

3.3.3.2 Dynamism of genres and contextualisation of HIV/AIDS consultations

Although genres are formed by specific conventions, research shows that they are vague categories with no fixed boundaries (Swales 2004; Bhatia 2004; Piqué-Angordans & Posteguillo 2006). This is clear from the view highlighted in these studies that many texts, written and spoken, cross into multiple genres by way of borrowing and recombining different generic conventions, thus relying on intertextuality and genre embedding. In written work, for example, the genre of descriptive writing provides vivid details of whatever is being described, expository writing explains

something, narrative writing tells a story, persuasive writing gives an opinion and then tries to persuade the reader to take a particular stand and technical writing tries to clearly communicate specific information (Applegate 2011). But due to their fluidity, a text such as a personal letter or a lecture can be both descriptive and exploratory at the same time. Literature, for example, is divided into three basic kinds of classic genres of Ancient Greece: poetry, prose and drama. Poetry could have subdivisions such as epic, lyric and dramatic; prose could be subdivided into the novel and the short story, while drama could be subdivided into comedy and tragedy. But comedy itself can further be subdivided into subgenres such as farce, satire and comedy of manners. Although there are many genres some of them could be collapsed into each other making the idea of delineating specific genres difficult. As a result, genres are often divided into sub-genres (Fairclough 2003).

In spoken discourse too, although the same rules of genre classification apply in which some, for example, sermons, lectures and debates are clearly distinct, others such as conversations, consultations and seminars are not as exclusive since they can employ more than one genre depending on the audience, context and purpose. Therefore, despite these specifications it is possible to have a text that employs more than one genre at a time. Also, one could find that one genre depends on the interrelatedness of other genres through genre sets or repertoires. This notion of 'genre sets' refer to a "range of text-genres that a particular professional group produces in the course of their daily routine" (Bhatia 2004: 53). This indicates that members of such groups use different genres to perform different tasks leading to the occurrence of genre sets, thus even though the genres comprising a set are individually distinct they are intertextually linked. In this way, texts from a particular genre set displays patterns that are found in similarly produced texts by other fellow professionals in the same field. However, he points out that this perspective is somehow limited because it presents the interaction from the side of the professional meanwhile the professional activity may involve other participants from within or outside the profession. So, in an attempt to account for the full set of genres i.e. all "the interrelated genres that interact with each other in specific settings" (Bazerman 1994: 4, cited in Bhatia 2004: 53) proposes the concept of systems of genres. Bhatia further indicates that, "the system of genres would be the full set of genres that instantiate the participation of all the parties…This would be the full interaction, the full event, the set of social relations as it has been enacted" (Bhatia 2004: 54). This gives more credibility to the view held in some research (Wright et al. 2008; Piqué-Angordans & Posteguillo 2006) that medical discourse of which doctor-patient consultations are a part, reflects different genre systems. It has already been pointed out that a number of virtual genres may be actualised in the same text depending on the audience and purpose of the interaction (Halmari & Virtanen 2005: 11`). All medical consultations are part of the larger category of medical discourse and are

interrelated. Since HIV/AIDS consultation is similar to consultations for other illnesses, it is an extension of medical discourse and it is therefore presumed that it will reflect genres that have been used in consultations and medical discourses as a whole (see Chapter 5, section 5.4).

The dynamism of genres is evident in discourse because it reveals the intertextual and interdiscursive nature of text when different texts are matched with other texts and genres with other genres (Halmari & Virtanen 2005). That is, consciously or subconsciously people compare the texts they encounter with other texts and detect similarities and differences between them. For example, the HIV/AIDS consultation can be compared to consultations with patients who have other chronic diseases; there may even be similarities with consultations involving psychiatric patients and terminally ill patients. Hydén and Bülow (2006) point to the use of illness narratives which also highlight the voice of the patient's life world and that of medicine (Mishler 1984; Roter 1991), and the use of stories in consultations in order to understand the patient's sense of identity and transformation of self due to illness (Hydén & Bülow 2006: 698). The emergence, maintenance, alteration and disappearance of some genres is attributed to intertextuality and the multiple voices it engenders in textual realisation (Halmari & Virtanen 2005; Bhatia 2004). However, the present study rather than focusing on the disappearance of genres acknowledges that HIV/AIDS consultations are part of medical discourse and thus may reveal evidence of spoken genres that come together and are being mixed in the consultation process.

3.3.3.3 Strengths and shortcomings of genres theory

The strengths of genres are the fact that they are versatile and dynamic in their linguistic categorisation so much that they allow interlocutors to benefit from their situations in view of their communication goals. Genre mixing or embedding of genres can be viewed in the light of interdiscursivity where a number of different genres may be actualised in the same text (Halmari & Virtanen 2005: 11). This is what may occur in the HIV/AIDS consultations as the interactants make their contribution to the consultation. Thus, the possibility of hybridity of and appropriation of various genres is investigated (Chapter 5, section 5.4). But this does not rule out the existence of individual genres because as Swales (1990: 34) has observed, specific text-types or genres serve conventional social uses and functions, that is, they attempt to do things in social institutions with predictable effects since they represent the ideas of different discourse communities. This suggests that genres vary from context to context and across time and cultures. Medical genres, especially the written genres have become stable through time in their form, structure and style mainly due to

the fact that the field of medicine is old (Piqué-Angordans & Posteguillo 2006: 651). But this does not make them fixed forever.

The versatility and dynamism of genres are also shortcomings because research (Bhatia 2004; Halmari & Virtanen 2005; Frow 2006; Piqué-Angordans & Posteguillo 2006) indicates that these qualities sometimes make it difficult to account for individual genres in linguistic analysis because they are continually subject to innovation and reinvention. Due to the difficulty of delimiting individual genres, they are sometimes treated in terms of prototypes, but mindful of the constant change and dynamism connected with them (Swales 1991). In some research the dynamism is even complicated, for example when Frow (1980: 78) refers to "discourse genre, or register". But in a later study he acknowledges that despite the shortcomings and inconsistencies of genre classification, genres are real and have an organising force in everyday life. But if genres are embedded in the recurrent practices of classifying and differentiating kinds of symbolic action and bind negotiations to the social situations in which they occur, the notion of intertextuality does not clear the confusion of distinguishing particular genres being used in specific contexts for specific purposes. Therefore, Foucault's (1972) idea that discourses delimit fields of knowledge and inquiry as well as govern what can be said, thought and done within those fields may seem rigid to define the nature and purpose of genres. He indirectly implies that each discipline and field of knowledge has its own specific genre but this is not always the case in practice.

3.4. ELF in medical discourses

This section focuses on the circumstances and some of the cultural issues that characterise lingua franca communication in medical discourse. It discusses some of the recommendations that have been made to help medical practitioners cope with the challenge of working with patients from mixed socio-cultural backgrounds. I discuss this problem generally but look at what is happening in the South African context in particular.

In essence, a situation in which any language is used as a lingua franca indicates multilingualism in the community and among specific participants. The communication that results is bound to be cross-cultural or inter-ethnic in nature. This is so because the interlocutors in multilingual situations belong to more than one speech community at the same time. The divergent beliefs and linguistic barriers that often exist between members of different cultures confront health care practitioners who are saddled with the difficult task of delivering good quality health care. Ramirez (2003), cited in Schouten and Meeuwesen (2006: 22) identify culture and ethnicity as a barrier in establishing an

effective and satisfying doctor-patient relationship. According to them, Ramirez points out that there is more misunderstanding, less compliance and less satisfaction in intercultural medical consultations compared to intra-cultural consultations (Schouten & Meeuwesen 2006: 31). He further observes that the doctors need a considerable knowledge of the cultural beliefs and way of life of the patients as well as the language component to enable them to communicate effectively and make medical decisions that are satisfactory to both parties. The lack of mutual understanding between doctors and patients belonging to different cultural groups has been identified as one of the obvious hindrances to inter-cultural communication (Schouten & Meeuwesen 2006: 31). They found that linguistic barriers could lead to a number of negative outcomes such as non-compliance, feelings of fear and lack of rapport. They noted that the inability to speak the doctor's language may even deter patients from seeking care and that poor language proficiency could negatively reflect on the quality of doctor-patient communication. This is an indication that a lingua franca which both interactants understand, is needed– such as English in the context of this study

The nature of cross-cultural medical discourse presupposes that the interlocutors have different cultures and may hold different beliefs about health, illness and communication. These may influence a consultation to some extent, resulting in misunderstanding that cannot be resolved merely by choosing one language over another. For instance, people's views and beliefs as well as their myths about HIV/AIDS in South Africa, are diverse and in many ways, will influence both the consultation and the treatment options they want. The doctors, from their bio-medical knowledge of the disease are required to make an effort to convince the patients to accept the treatment options available to them. However, Orr (1996) suggests that it is of vital importance for the doctor to understand the beliefs and values of the patients in order to better understand their illness and response to it. Responding to the illness also involves making known medically appropriate decisions to the patient in a language that s/he understands. Coining leaves marks on the body that can be mistaken for physical abuse. He also mentions a more serious issue like female circumcision which is still practiced in some parts of Africa. This is a cultural practice that is painful to the child. The point he wants to make, is that a doctor examining a patient from a background with these cultural practices and having an L1 unfamiliar to the doctor might face some difficulty. He/she might draw wrong conclusions and eventually also diagnose incorrectly because of the patient's inability to explain what the marks (symptoms) are. The need for mutual understanding is therefore very important, and a lingua franca is one way of achieving this. The need for a language that is intelligible to both parties is therefore very important. For example, in Baghdad, Iraq, where deeply entrenched religious beliefs, poverty and illiteracy are rife; some people are reported to view disease as demonic attacks and witchcraft, a perception that is quite different from that of the

attending physicians. The doctor must then try to negotiate a degree of understanding of these cultural dynamics in order to provide effective medical care to the patient. Consequently, although the physicians view the medical encounter as a tool of diagnosis and therapy, patient-clinician communication may be confounded because of limited knowledge and different beliefs of the rural society and its people and so render their work more difficult (Orr 1996). He suggests that a better understanding of the patient's beliefs will allow the clinician to find compromises and reach agreements, which they would otherwise not have considered. Since language is the vehicle through which these beliefs are conveyed, it is then important for the two interlocutors to be able to use a language that is mutually intelligible.

Williams (2006: 29) also highlights some of the communication barriers that doctors face as a result of the differences in both their cultural beliefs and world views. He explains that a Xhosa-speaking patient for instance may perceive 'fits' as an act of witchcraft or a cultural form of 'demonic possession' that can be treated by some form of traditional 'cleansing'. Meanwhile a doctor's western biomedical diagnosis will call the same condition 'epilepsy' and see it as a nervous disease that needs medical treatment. These opposing views could result in a breakdown in communication during a medical consultation and could have serious implications for diagnosis and the treatment. Schouten and Meeuwesen (2006) refer to the explanatory model (EM) which says that, 'the notions about an episode of sickness and its treatment must be those that are employed by all those engaged in the clinical processes' (Kleinman 1980, cited in Schouten & Meeuwesen 2006: 29). He points out that an effective consultation is one in which the doctor and the patient agree on the EM. The doctor's EM is one that uses the biomedical evidence of the disease and the EM of the patient is based on biomedical evidence as well as cultural and personality factors. Agreement in terms of what explanations are given for the diagnosis and treatment needs to be achieved. Although the EM-approach may appear interesting, it might not always be practical because sometimes whether the patient agrees or not, the doctors are informed by the biomedical evidence of the illness which they are asked to treat. Therefore, the emphasis should not be only on the model *per se* but also on the language that is used to explain things to the patient.

3.4.1 ELF in medical discourses in South Africa

Bearing in mind the multilingual nature of the South African society, communication in the medical setting can take place in any of the eleven official languages recognised by the constitution– and in fact, even in any other languages such as Portuguese (e.g. with a Mozambican migrant), Spanish (e.g. where a Cuban doctor meets an Argentinean visitor) or Kiswahili (e.g. where doctor and

patient are Kenyan migrants). The language choice at any given time is partly determined by the physical location of the interactants and partly by the linguistic repertoires of the doctors and patients in a specific setting. Statistics South Africa (2003) refers to the right of South African citizens to be helped in an official language of their choice. However, there is no prescription about exactly which language is to be used in any one facility. In the Western Cape, for instance, Afrikaans, English and Xhosa are the most used languages. But although Afrikaans is the most widely spoken language in the province, English is used as a lingua franca in cross-cultural communication in many situations. This is especially true in situations involving other nationals as well as where interlocutors have varied L1s in medical consultations (Williams 2006: 28). The ethnic neutrality of English has been identified as a reason for its prevalence during such cross-cultural communication and ELF has the advantage that a vast majority of people are learning and using it for various communication purposes (De Klerk 1996; Meierkord 2006b). English is therefore often used for practical purposes especially in a context that involves a diversity of race groups Williams (2006: 26) points out that this is the case in South Africa, where there is an increasing flow of Africans migrating from what he calls the bordering 'homelands' to the cities in search of employment, education and health care.

In South Africa, patients have the right to express themselves in their own language. The health facilities would require the services of interpreters to help them communicate with patients using languages other than their own, if they cannot use a lingua franca in communicating with the patients. Probably due to issues of possible stigmatisation and confidentiality surrounding HIV/AIDS, patients often prefer to use ELF rather than having an interpreter during consultation, even though they themselves have limited English proficiency. This would guarantee confidentiality and may be save them the embarrassment of telling their most intimate experiences to the doctor through a third person

3.5 Summary

This chapter discusses the different conceptualisations of the term 'discourse' in various disciplines and also the different approaches that have been used in the study of medical discourse, highlighting the paradigm shift from the biomedical and paternalistic approaches to doctor-patient interactions presented in earlier research as opposed to the patient-centred and partnership model that has been advocated for the last two decades. The chapter also highlights some of the issues and foci of medical discourse research such as doctor-patient asymmetry, the use of questions as well as the influence of the socio-cultural context on doctor-patient interactions although not all of these

aspects are investigated here. Various relevant theoretical approaches that have been used in the study of language use in different disciplines are also discussed. The discussions in the chapter then proceed to identify the theoretical framework of the study, giving detailed information on DA and CA as theories that are applied in the study and which are very relevant as far as the study of naturally occurring discourse such as the HIV/AIDS consultations is concerned. In this regard, I discussed both the strengths and limitations of these approaches, while also exploring the different linguistic features that are central to them especially in relation to the present study. Finally, the chapter ends with a brief discussion of the use of ELF in medical discourse in the South African context in particular.

CHAPTER FOUR
RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This chapter describes the research design that is based on a qualitative approach and the procedure involved in data collection and analysis. It highlights the characteristics of qualitative research, shedding light on the understanding of the functional and formal aspects of naturally occurring interaction. It discusses the strengths and weaknesses of qualitative research. It describes the specific method that has been used to address the research questions, providing specific information with regard to the application of both CA and DA as theories that underpin the audio-recording as method and highlights the transcription conventions used. The chapter also discusses the ethical issues involved in the conduct of research with human subjects, particularly the HIV-positive patients and the doctors in the present study. It provides detailed information on the procedure involved in obtaining ethical clearance, the selection of research participants and research sites.

4.2 Research design — qualitative research

This is a qualitative study that uses analytical tools from CA and DA to investigate the use of ELF during doctor-patient consultations at four HIV/AIDS clinics. There is little consensus amongst qualitative researchers as to what the critical features of qualitative research are because qualitative research uses a wide spectrum of techniques of data production, collection and analysis to investigate people's understanding of their lives and social context. These range from textual or non-numerical data to the explicit employment of distinctive and epistemological theories such as grounded theory, phenomenology or ethnography (Holloway 2005: 95-99). Qualitative research developed largely in disciplines such as Anthropology and Sociology but its methods have become established in other disciplines such as Education, Social Policy, Social Psychology, Organisational Studies, Human Geography, Sociolinguistics and Health Sciences (Denzin & Lincoln 1994, cited in Avis 2005: 3).

Qualitative research covers a wide spectrum of investigation. This includes the study of documents such as bureaucratic records, newspaper reports, family pictures, home videos, cartoons, email messages, and so on (Ten Have 2004: 6). Thus any form of preservable record of text, sound, image or a combination of these may be a source of data. Such documents can serve as "resource" or "topic" (Ten Have 2004: 8). Alasuutari (1995) identifies two distinct approaches to qualitative

research: the "factist" and the "specimen" perspectives. From the 'factist perspective', the research material is not studied in itself but rather treated as evidence for happenings and conditions elsewhere in the discourse (1995: 47). This is in contrast to the 'specimen perspective' in which the "research material is not treated as either a statement about or a reflection of reality; instead a specimen is seen as part of the reality being studied" (1995: 63). The latter is the case when the analysis of an interview focuses on properties of actual interaction or the characteristics of the language used in particular contexts. The present study draws inspiration from the specimen perspective because even though the doctor-patient interactions provide factual information about particular details of the condition of the patients, the consultations in this case are not used by me for finding out any facts about the patients and their condition from a bio-medical perspective or even about the social relationship between the doctors and their patients. Rather, the dialogue in itself is the material that is investigated to discover the linguistic and discursive features that characterise such discourses and how interactants use the linguistic resources they have in ELF to relate to each other and resolve any misunderstanding that arises.

I approach this study from the theoretical perspective of DA and the more specialised field of CA because the data are based on actual consultations. These approaches have been chosen because the study aims at identifying linguistic and discursive features that characterise HIV/AIDS communication in English, where the interactants do not have a common L1 and therefore rely on English as a lingua franca. The study investigates how cross-cultural communication takes place in such circumstances, and attempts to determine the effect of using ELF in medical discourses. The study also aims to find out how interactants resolve misunderstanding when it occurs, using ELF.

4.3. The characteristics of qualitative research

4.3.1 The use of textual data

Qualitative researchers usually employ research questions that seek to understand social behaviour by exploring people's subjective accounts of social life, by giving priority to obtaining and analysing textual data, be it oral or written (Avis 2005: 4). Qualitative research predominantly uses methods that produce text; research results are presented in verbal expressions rather than numerical summaries and tabulations as is the case with quantitative research. Such data would include transcripts of interviews and conversations, questionnaires, diary entries, observation notes, entries in medical and nursing records (Avis 2005: 5). The importance and benefit of working with textual data is that they allow people to express their thoughts and beliefs in their own words and on their

own terms. The emphasis on text allows the researcher to accept the importance of unexpected and unanticipated information as well as preserve the narrative and social character of the conversation. The consultations in this study constitute part of everyday conversation between doctors and patients at the clinics. Thus, the theoretical approaches chosen for the study should enable the researcher to identify various linguistic and discursive features and communicative patterns that characterise consultations as a genre, and to figure out their uses in this context. The data for the present study are therefore basically verbal, based on transcriptions of audio-recorded material i.e. actual recorded conversations between health workers and patients during HIV/AIDS consultations.

4.3.2 Interaction with the people being studied

Qualitative research relies on extensive interaction with the people being studied (Avis 2005: 5). This is done through field work or ethnography, a label which indicates any form of research that involves on-site observation and interaction with the participants, who could be medical personnel and patients in hospital or any variety of people at work. In other words it refers to research that involves the researcher leaving his or her office to visit the research subjects in the environment in which they spend the research-relevant part of their lives (Ten Have 2004; Avis 2005). The reasoning here is that in order to explore the meanings that people attach to their experiences or view the social world through the eyes of participants, it is necessary for the researcher to interact with them for an extended period of time in a fairly unrestrained manner (Avis 2005: 5). The present study is not based on such sustained participation in the consultation context because although the researcher intended to get some insight into the life experiences of the participants at the HIV/AIDS clinics from a linguistic perspective, personally her interaction with them was limited largely due to consideration of the privacy and confidentiality afforded participants. Her interaction with the interactants was limited to just the time that was necessary to request consent. to collect the recorded consultations from the doctors, and is to a large extent therefore non-participatory because she is not directly involved with the collection of data. Therefore, the methodology used here can be classified under what some researchers have referred to as ‘condensed ethnography’ (Avis 2005). So even though she went for ‘field work’ to collect data she did not herself directly interact with the participants. Nonetheless, the exercise was time-consuming, and sometimes required continuous improvisation due to the unpredictable nature of life outside the researcher’s space and the uncertainty of dealing with people. The advantage of using this approach even just for data collection (as in the present study) is that the participants are not regarded as passive subjects but active contributors to the research project (Ten Have 2004). This approach portrays the researcher as learning from people by personally witnessing or going

through their life experiences with them rather than studying them (Spradley 1979, cited in Avis 2005: 5). This is done in the present study by analysing what the participants say in the audio-recorded conversations during the HIV/AIDS consultations.

4.3.3 A flexible plan of inquiry

Qualitative research involves a flexible plan of inquiry that evolves as the study progresses. This is because the researchers rarely have any rigidly predefined protocol for sampling, data collection and analysis (Avis 2005: 5). For example, the researcher in this study originally intended to make use of video-recordings of consultations which she personally observed, but considering the sensitivity of the context and respecting the privacy of patients and physicians in consultation, this decision was revised so that only audio-recordings were done with the assistance of the physicians. The original intention was to also get data that reflected gender parity but this was not the case in the field because there were just too few male participants. This flexibility allows the researcher to adapt the methodology to suit the prevailing conditions. This can be done by expanding or reducing the samples, using new methods or employing extra-analytical techniques. In the case of the present study, the sampling was adjusted in terms of the time spent on fieldwork and participant gender parity (to be discussed in more detail in section 4.5.4 below).

This type of study requires personal involvement, an abandonment of traditional scientific control, and uses an improvisational style to meet situations not of the researcher's making (Agar 1986: 12, cited in Avis 2005: 6). This provides the opportunity to learn from mistakes. Avis (2005: 6) refers to this as reflexivity and is of the opinion that this aspect of qualitative research gives the researcher the opportunity to reflect on their role in the social process of producing data. Therefore, the researcher has to decide whether s/he is going to be actively involved in the data production process or will simply be passive and less intrusive (Ten Have 2004; Avis 2005; Holloway & Todres 2005). In this study the researcher was minimally intrusive in the data production and collection process. Avis (2005) points out that since the researchers cannot rely on the replication of their techniques to establish credibility of evidence as it is done in quantitative research, they rely instead on the transparency in their decision-making which can be traced in the data. This involves leaving an audit trail about gaining access, selection of field role, choice of participants, ethical considerations and analytical methods. This is important because the researcher demonstrates the credibility of evidence by allowing the reader to see through his/her decision-making and analytical approach to the data.

Qualitative research is also flexible because there is overlap in the procedures and techniques used in the different approaches. These different approaches often share the philosophy of person-centeredness and search for meaning in the accounts and/or actions of participants (Holloway & Todres 2005: 90). Flexibility is important because it respects the primacy of the topic or phenomenon to be studied and allows for a methodological approach and strategy that are suited for a particular enquiry. This decision is necessary because a number of qualitative strategies and skills are generic, for example, interviewing and thematisation. However, flexibility in approaches and methods can lead to inconsistency and lack of coherence in the value and integrity of particular methods since some of them are distinct and different in their nature (Holloway & Todres 2005: 90). But it is possible to transcend these differences by proposing an approach that allows for flexibility, consistency and coherence in the methods i.e. an approach that takes into account the appropriateness of a particular method rather than just method for its sake (Janesick 2000, cited in Holloway & Todres 2005: 92).

4.3.4 Emphasis on naturalism

Another characteristic of qualitative research is that it emphasises naturalism by trying to understand the experiences of the people that are being studied and their interpretation of their social world. For this they use techniques that are familiar to the participants, respecting their beliefs and assuring that the study reflects a normal social interaction. (Avis 2005: 6). In the case of the present study for example, the participants are quite familiar with the practices of audio-recording; however, even though they give their consent to such recording and admit to 'ignoring' it during the consultation, it is difficult to say their consultation is completely unaffected by it. But it is important that the consultations are real life situations of actual conversations between doctors and patients presented as these regularly occur. Thus it is impossible to avoid any manipulated social settings as would have been the case with an experiment in a simulated environment or even with the use of highly structured or formal interviews. This commitment to naturalism is to emphasise and not overlook the fact that any form of investigation is likely to influence participants' behaviour. Therefore the data must capture details of both the discourse and the context in which it is occurring naturally. The use of interactive discourse such as the consultations in the present study and the emphasis on reflexivity therefore recognise the fact that the research is itself a social process that is open to interpretation and change (Ten Have 2004; Holloway & Todres 2005).

4.3.5 Wide scope of application of findings

Finally, the way in which the findings in qualitative research can be applied to other settings, makes it appealing to researchers. The focus of providing a contextual understanding of particular social processes like the HIV/AIDS consultation from an individual's point of view means that the researcher is less concerned about producing findings that can be generalised to a wider population (Avis 2005: 7). However, this does not mean that the findings cannot be applied to a broader range of settings than those of the specific study. The findings of the present study can be applied to and related to communication in ELF in cross-cultural settings elsewhere, and particularly to such uses in medical consultation where other kinds of medical conditions are dealt with. Such application of findings to other groups or contexts shows that the findings are credible in the light of existing theory and that they are consistent with social theories that have wider application.

4.4. Strengths and limitations of qualitative approaches

As expected, qualitative approaches have both strengths and weaknesses. First of all, a clear advantage is that such analyses have high validity because they focus on discourses within their larger semantic and natural setting. The use of data collected through audio-recording gives more credibility to the findings since these can be verified through a replay of the audio-recordings. Furthermore, texts are produced through non-obtrusive strategies such as audio-recording that reduce reactivity and researcher subjective observation effects. However, these approaches have limitations such as the lack of control over the data that is produced because the interaction develops by the moment. Conversely, the findings of such studies can be considered limited and lack transferability due to the context-dependent nature of these discursive practices (Mouton 2003; Avis 2005). This would make it difficult for conclusions drawn from the study to be applied to a larger sample or claim applicability of some findings to other settings than those investigated (Smit 2010: 87-88). In order for such results to be applied elsewhere, one would need to make strong arguments to show that they are credible in the light of existing theory and consistent with social theories that have wider application (Avis 2005:7). Furthermore, some of the methods used in these approaches like audio-recording employ transcription conventions that result in inevitable losses of certain features due to the selective reduction, simplification and idealisation which are the effects of these processes and the decision of the researcher (Ten Have 2004). This would make the conclusions subjective to the whims of the researcher and not a true reflection of the reality of the phenomenon being investigated.

4.5 Methodology

As discussed in Chapter 3, section 3.2.1, a lot of research has tended to favour the complementarity of integrative approaches. In this study, I have decided to combine both the CA and DA analytical tools to have a clear understanding of the linguistic and discursive features that characterise HIV/AIDS consultations. Hopefully, this approach will enable me answer the research questions I outlined at the beginning of the study. Sections 4.5.1 and 4.5.2 present specifically how CA and DA are respectively applied in the present study.

4.5.1 Applying CA to the present study

This section discusses the way in which the CA approach is applied in the present study and to what end. CA studies how social acts are organised in interaction and how they are packaged and delivered in linguistic terms. It offers a descriptive framework for detailing the practices and resources social actors (like doctors and patients) use to collaboratively create and socially constitute interaction for cooperation and resistance in social life (Ford et al. 2002). CA focuses on the description of the interactional construction of turns and sequences and in the production and interpretation of interactive meanings in the collaborative creation of social structure (Ten Have 2004: 25). This means that both doctors and patients co-construct the medical encounter and manage to exchange information that helps them perform their different tasks. Consequently, CA will be used in the present study as a research tool to enhance the description of linguistic and communicative features by selecting particular sequences from the recorded data and analysing the linguistic features and the actions that are identified in them. CA aims to establish patterns and trends in interactions through systematic identification of occurrences of a particular phenomenon and detailed analysis of single instances of the phenomenon. So, the researcher will use CA to describe the structure and organisation of the turns, sequences and repair as well as the impact of ELF in their content and structure within the interaction. However, the analysis will not include considerations of micro analytic detail at the phonetic level that CA as a method for analysis entails. Thus, phonetic units resulting from the different varieties of English used by the participants in the clinics will not be emphasised in this case. But it will focus on the macro-context of ELF and how it impacts on the HIV/AIDS consultation and how the consultation is structured to facilitate or hinder the efficacy of the communicative encounter. With regard to turn-taking organisation, the researcher will consider speaker change and selection with respect to determining who initiates more turns, who speaks more when and why? (turn size), interruptions or overlaps, and how turn-taking is generally locally managed and controlled within the interaction. In examining the

sequential organisation of the interaction, the researcher will consider the presence and use of adjacency pairs such as question-answer pairs, as well as the recurrence of similar sequences. In terms of repair organisation, the researcher will examine how repair sequences are initiated and by who, how topic changed is initiated and managed; and whether repair efforts are successful in resolving misunderstanding especially bearing in mind that the interactants are using ELF in which they have varying competencies.

Since CA does not generally consider contextual categories such as power in order to explain interaction and talk, unless these emerge in the interaction or are made relevant by the participants themselves (van Dijk 1999), this study will do same. Also, the non-verbal aspects of the HIV/AIDS consultation are not included in the study partly because it is not the objective of the study and because CA investigation mostly considers the spoken word. It is of interest to the researcher to know for example how the discourse is generally structured given the inter-cultural nature of interactions in the clinics. Moreover, considering the multilingual nature of the South African society it is interesting to find out how the use of ELF in the midst of other national languages affects the communication in health facilities.

4.5.2 Applying DA to the present study

Considering the foregone discussion on various DA approaches, it is important to establish the scope of application of DA in the analysis in the present study. Discourse analysis covers the study of both the spoken (which is the focus of the present study) and written interaction as well as the effect of the socio-cultural context on the use of language. A medical consultation is not a neutral exchange of information; it is a form of discourse which reveals social features in the sense that it is an interactive process involving the doctor and the patient as social agents of their own identities and as representatives of their worlds (Hall 1997). Linguistic features used in actual communication between the participants are bearers of such social meanings. The interactive nature and linguistic features that constitute medical discourse are both aspects of doctor-patient communication that have received limited attention in social-medical research in the South African context. Therefore DA is used in this study to explore the manner in which socio-cultural features such as the doctor's expertise and the multilingual background of the participants impacts the speech of the interactants in the specific setting of the HIV/AIDS clinics as they engage in interactive dialogue.

DA is suitable for this analysis because part of the investigation is to determine the effect of the socio-cultural background and the context on the language used for HIV/AIDS consultation where

ELF is the medium of the interaction. The intention is to explore the situated nature of language use as displayed in the linguistic and discursive features of the HIV/AIDS consultations in ELF. However, a single DA approach from those discussed above can only explore specific aspects of the discourse. Consequently I have decided to use an approach that merges 'identifying codes' and 'use and interaction' discussed in Chapter 3, section 3.3.2. I have adopted this approach because the study aims at investigating the discursive features of doctor-patient communication paying particular attention to identifying characteristic linguistic and discursive features and their functions in this form of discourse in a situation where English is a lingua franca. Furthermore, DA research has the added advantage of working with tape recordings which are the primary source of data for this study. This gives both the researchers and the readers an opportunity to experience the world view of the participants first hand through what they say. Some research (e.g. Potter & McKinlay 2005) indicates that the detail in talk and text is potentially consequential for interaction even though this study discusses only those aspects of interaction that are salient in the recordings. The use of this type of data gives both validity and credibility to the findings as they are based on the actual utterances made by the interactants.

DA is suitable for this study because it is an approach that allows the analyst to select what aspects of the data are relevant to them; in the transcription the detail given in diacritics and other metadata are selected to fit the purpose articulated in the research aims. The researcher can leave out the transcription of communicative features that are not relevant to his/her study, which is what I have done in this study. I will consider sociolinguistics and applied linguistics as integral parts of this study since they are concerned with the structure of social interaction manifested in conversation as well as the description of linguistic features that characterise such discourse (Brown & Yule 1986). In this study, the structure of the interaction is manifested in conversational rules like turn-taking, repair and sequencing, while the social context is that of the state clinics where the consultations are taking place. These aspects are all vital to DA research and central to this study.

4.5.3 Ethical clearance

'Ethics' generally refer to the moral standards or values by which human conduct is judged. This is a moral agreement made in behavioural research which prohibits the researcher from doing physical or psychological harm to the participants, to take such responsibility and to do beneficent research in a way that will likely produce valid results. According to Akaah and Riordan (1989: 113) "the issue of ethics derives from a researcher's relations with parties in the research process, including respondent, client of research agencies, clients of research departments, and the general public".

They point out that each of the parties is owed duties and responsibilities where the researcher for example has the responsibility to treat respondents fairly by being truthful to them about the nature and the purpose of the research study. But they also highlight the fact that fulfilling these duties can cause conflict and give rise to a research ethics problem whereby the researcher may not be completely candid with the respondent about the intent of the study to avoid biasing their responses. This was not the case with the present study because the researcher was honest with the participants about the nature and intent of the research.

The ethical requirement of research ensures that the researcher does research that is benificient in a way that will produce valid results. This view has been supported by researchers like Cameron who points out that, "empowering research must give attention to the research process as well as the research product" (Cameron 1992: 121). Therefore, considering the fact that the research topic is centred on a very sensitive issue like HIV/AIDS, due ethical clearance was obtained from the University's Research Sub-Committee A and the clinic authorities. Also, informed consent was sought from every participant who was duly informed about the nature of their involvement as well as the nature of the study and instruments of data-collection to be used, namely the audio-recorder.

The confidentiality and anonymity of the participants have been guaranteed through the omission of their real names. All the doctors are identified using the codes in section 4.5.4 below while the names of the patients that were expressly mentioned during the consultation have been replaced by the first letter of the name, written as a capital letter in the transcription. For example 'T' could stand for a patient called 'Thomas'. Otherwise, the rest of the patients are referred to just as 'Patient' or 'Patient 1' and 'Patient 2' if there are two patients in the consultation room at the same time. Patients and doctors involved are referred to at different times in the study as, participants, interactants, interlocutors or research subjects. All have the right to decide to withdraw from participating in the study at any stage, even if they had given consent at an earlier stage, without any fear of victimization. This did happen as seen in section 4.5.4 below where one patient withdrew during a consultation; others that had initially consented, refused to be recorded at the start of the consultation.

4.5.4 Research participants

The participants in the present study are doctors and HIV/AIDS patients who are on ARVs. These were contacted in four HIV/AIDS clinics in the study area. The doctors and patients were contacted

in person before the onset of the consultation and they granted consent to participate in the research. All the participants were NNS with different L1s but used ELF for consultation.

i) The Doctors

A total of four doctors participated in the study, three females and one male. All of them have been actively involved in the treatment of HIV-positive patients for at least two years. They were informed of the study first through the Superintendent of HIV/AIDS clinics in the area and then contacted in person in separate meetings by the researcher to explain the purpose of the study and to solicit their consent and assistance before the study began. Each of the doctors signed two consent forms, retained one copy and handed the other to the researcher for record purposes. They were selected by default since they were the doctors working in the clinics at the time of the study. For ethical purposes and the anonymity of these participants, they are coded and referred to in the study as Drs A, B, C and D. There was no gender parity with regard to the choice of doctors for the research because there were more females than males working in these clinics. As it is, the relationship between gender and language use was not an objective of the study. Gender was therefore not a determining variable for the choice of participants. I cannot say if this was a conscious decision on the part of the clinic administration but the ratio of the male-female doctors was by far higher for females, so that the researcher's decision to work with those that were present and willing to participate in the study, reflected the gender distribution as it is.

Regarding their linguistic background, Doctors A, C and D have Afrikaans as their L1 while Dr B is Xhosa but speaks Mosotho. However all of them use ELF as the language of consultation with the patients in the study, even though Dr. B shares Sotho as lingua franca with one patient. Since the doctors were selected by default the researcher made it clear to the nursing sister that the only patients who were eligible for inclusion would be those who did not share the same L1 with these doctors and who instead of using an interpreter chose to use ELF for consultation.

ii) The Patients

The patients who were approached and who later took part in the study were all HIV-positive adults within the age bracket of 18 to 65. The lower age limit was chosen because the researcher wanted to work with patients who had reached the legal age to take responsibility for their decision and consent. As can be seen in section 4.5.6 they were first contacted by the nursing sister who had been briefed by the researcher regarding the purpose of the study and the criteria for selection. All

the patients had an appointment to see the doctor regardless of whether their visit was the first one where they were beginning treatment or if it was a follow-up on previous visits. Patients were first approached by the Nursing Sister who had been briefed by the researcher about the purpose of the study and given the criteria for selection. The interested patients were later introduced to the researcher who then explained what the study was about in more detail. She also took them through the consent forms individually before they were completed and signed. In the same way as the doctors, each of them signed two forms, retained one in their folders and returned the other to the researcher. The researcher could only meet the patients on the days of their consultation and not before, due again to ethical considerations.

As with the doctors, gender parity was not possible with the patients because there were more female than male patients at the facility and even fewer male patients who consented to take part in the research. There were a total of 25 patients who signed the consent forms, 14 females and 11 males. Of this number only 19 eventually got recorded (11 females, 8 males). Four patients (two males and two females) later discovered that they actually did not have an appointment to see the doctor that day, and one patient (male) withdrew from participating in the course of the consultation and so the recording was excluded from the study. One female patient used an interpreter and the recording too was automatically excluded because it did not meet the inclusion criterion of communicating directly with the doctor in ELF.

To return to the linguistic background of participants, it has to be mentioned that most of the patients (thirteen) were isiXhosa L1 speakers (seven females, six males). The rest comprised of one (female) Sesotho L1 speaker, two Afrikaans (females) and three foreign nationals (males) from a neighbouring African country whose L1 the researcher could not determine because she only discovered their nationality from listening to the recordings. Given this linguistic scenario, ELF became the common language and language of choice for the consultations.

4.5.5 The research sites

The study was originally intended to be conducted at one specific clinic at which the pilot study had been carried out earlier, but due to the fact that this medical facility already had many researchers from a number of different disciplines carrying out research there at the time the ethical clearance for this study was granted, this plan had to change. The authorisation from the Department of Health had allowed for the study to be conducted in any other clinic in the area that was willing and equipped to accommodate the researcher. So during the course of the data collection, the researcher

travelled to and from four different clinics scattered in this area. However, although the clinics are located in different areas the set up in all of them is basically the same. In each of the four clinics, there is a general sitting area that serves as the waiting-room and reception for the patients which usually links to the pharmacy. Then somewhere in the same building and close to this is the doctor's consultation room which is always located closest to the Nursing Sister's room where the patients go to perform activities such as taking their weight, checking their blood pressure, drawing blood for tests and waiting to be ushered into the consultation room. A little further away from the doctor's room are the rooms for the Dietician who gives advice on dieting and the Adherence Counsellor where the patients go to count their pills and the Counsellor makes a record of their adherence since their last visit. In all the clinics, there is an extra room that served as a makeshift sitting room where the researcher met with the patients who had agreed to take part in the study to explain to them what the study was about and to let them sign the consent forms.

4.5.6 Collection of data

Qualitative research offers a wide variety of methods, aims and approaches (Ten Have 2004; Nixon & Charmaine 2007). Researchers in medical research and particularly doctor-patient communication have used methods such as case studies, interviews and questionnaires, audio- and video-recordings, ethnographic and participant observations to investigate and highlight different aspects of the interaction. For example Cordella (2004) highlights the dynamic nature of doctor-patient communication using a Chilean clinic as case study. Williams and Ogden (2004) used interviews and questionnaires to investigate the negative impact of doctor-centred consultations on the patients and treatment outcomes and the impact of matched and unmatched vocabulary of doctors and patients during consultations. Several researchers have used audio-records for data collection in their studies. For example Jefferson (1985, cited in Ten Have 2004: 43) used audio-recordings in the transcription and analysis of laughter, Watermeyer (2008) investigated pharmacist-patient interaction using audio- and video-recordings as well as participant observation. Anthonissen (2010) also used audio-records to investigate how linguistic diversity in South Africa is managed in HIV/AIDS clinics. Coleman (2000) highlights the advantages and limitations of using video-recorded consultations for research in primary care.

Participant observation is a method that is used in the Social Sciences and involves the researcher taking part in the daily activities, rituals, interactions and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and their culture (Dewalt & Dewalt 2002). They indicate that few researchers engage in the systematic use of information gotten

in this way only for scientific purposes because it presents a subjective perspective of the phenomenon under investigation. The goal in the present study is to understand the nature of the phenomenon of ELF in a naturalistic setting where both interactants have different L1. In this case the researcher is interested in investigating how people use English in this multicultural context to express an aspect of the clinic culture and in negotiating treatment-related decisions. The knowledge gained through personal observation could help clarify the researcher's understanding of the role English plays in this context to enable interactants achieve their communicative aims in the consultation. Although it was not used as a method to collect data for this study it provided some supportive evidence from the researcher's perspective. This is also due to the fact that there was little access to data that could provide such knowledge in this study because the researcher was not physically present in the consultation room. However, she observed the activities that took place in the clinic between the patients and clinic staff. So, bearing in mind the research questions and the ethical consideration for the participants in this research, I have chosen audio-recording as the primary method for the present study. This is complemented by a limited amount of ethnographic information about the participant selection process at the clinics provided from the researcher's personal experience and observations outside the consultation room during the period that she was at the clinics (see Avis 2005).

The data collection spanned a period of seven weeks instead of the eight that were originally planned because of reasons beyond the researcher's control. Consequently, instead of the 40 recordings that were envisaged, the researcher ended up with a total of 25 of which only 19 consultations met the language criterion that was used. The data were collected in four different HIV/AIDS clinics in the study area in the relatively developed rural area in the Western Cape, identified as the site for this research. These data consisted of recordings of the interaction between the doctors and patients (the consultation) on issues of HIV/AIDS and treatment, carried out in ELF. The recordings were done using a portable digital voice recorder. In the following section I focus on the method that is in my opinion most suited for this research and explain how the entire recording process was done.

4.5.7 The audio-recording process

Ten Have (2004: 41) observes that most studies that belong to the family of ethnomethodology and conversation analysis use recordings (audio or video) of actual 'natural' interaction as their only data source. The present study has used audio-recording. The process begins with the researcher communicating with the Superintendent of the clinics in writing and in personal conversation about

the purpose of the study and requesting permission to carry out research. Then it continued with the researcher personally meeting with all the doctors working in the four HIV/AIDS clinics to discuss the purpose of the study, solicit their assistance and consent to take part in the study. After this, the doctors signed two consent forms each to indicate their voluntary participation, retaining one copy each for themselves and handing the other to the researcher. On the day of the consultation, the nursing sister uses the inclusion criterion provided by the researcher to identify patients who are eligible for the study and takes them to a reception room where she informs them of the aims of the research project and the request of the researcher. The patients that are not prepared to take part in the study may leave immediately; those patients that are willing to participate in the study remain. Then the researcher who has been waiting elsewhere is called in and introduced to the patients. She thanks them for agreeing to meet her and explains in detail what the study is about. At this point she makes it very clear that the patients have the right to withdraw from the study at any stage of the study if they feel uncomfortable or apprehensive about anything.

The patients are also each given two consent forms which they sign. One copy is put in their hospital folder which is later taken to the doctor during consultation, and the other copy is handed to the researcher as evidence that they are taking part in the study out of their free will. The patients then return to the waiting-room to wait for their turns to see the doctor. The researcher is allowed into the consultation room before the consultation begins to set up the recording equipment and hand over the responsibility of doing the actual recording to the doctor. When she leaves the consulting room and goes to wait within the facility, the nursing sister accompanies in the participating patients to the consultation room. The doctor differentiates the folders of the patients who are participants in the study from the rest of the folders through the copies of the signed consent forms which were placed in their folders after their meeting with the researcher and the Nursing Sister. The signed consent form assures him/her that the patient has given approval to be recorded and that they have not been coerced. The recording begins when the conversations between the doctors and the patients start. These conversations are audio-recorded by the doctor who is carrying out the consultation. Often, some of the doctors verbally verify the patient's consent in order to get it on record.

Ten Have (2004: 41-52) discusses the importance of audio-recording and highlights several reasons for its use as a method of data collection. First of all, the transcriptions produced from the recordings give access to details of the formal organisation of verbal interaction in the individual consultation sessions as they occur moment by moment. Secondly, the recordings are then replayed repeatedly to capture the moment-to-moment fine-tuning which reveals the communicative

strategies that conversationalists practise but which they may not be able to remember or explicate. Audio-records allow the details of actual human action i.e. what happened, to be subjected to close scrutiny and formal analysis through the replays. Thirdly, the fact that this information can be put on display gives the researcher and others the opportunity to study the data extensively. Furthermore, audio-recordings and their transcripts enable the researcher to share access to the data as well as check researcher's subjective perception since the analysis is data-driven. Therefore, the data display the empirical grounds for the researcher's analytic results for others to see. The availability of audio-records enables repeated and detailed examination of particular events in interaction and hence greatly enhances the range and precision of the observations that can be made. The use of such materials has the additional advantage of providing hearers and to a lesser extent readers of research reports with direct access to data about which analytic claims are being made, thereby making them available for public scrutiny in a way that further minimises the influence of individual preconception. Furthermore, the use of recorded data serves as a control on the limitations and fallibilities of intuition and recollection of the researcher, providing a guarantee that analytic conclusions will not arise as artefacts of intuitive idiosyncrasy, selective attention or recollection or experimental design (Atkinson & Heritage 1984: 12). It is important to note that with the advance in technology, audio-recording has become a suitable and popular method for this type of study because of the small size of the modern recorder which makes it easily transportable and less intrusive, lessening the resistance to its use. So, the sheer convenience and precision of audio- and video-recordings have made them increasingly popular.

4.6 Data transcription

At the end of the fieldwork, the data consisting of a total of 19 recorded consultations are used by the researcher to produce transcriptions of the verbal language in the interaction. Bearing in mind the research questions and what analytical tools are needed to answer them the transcription is done using the following list of selected transcription symbols adapted from Ten Have (1999: 213-214, 2004: 183-184) also presented as Appendix E:

[[	Start of simultaneous utterances
]]	End of simultaneous utterances
[	Beginning of overlap
]	End of overlap
(0.0)	Intervals within and between utterances measured in tenths of seconds
:	Extension of the sound or syllable it follows

:: More colons indicate much longer sound or syllable

word Underlining indicates emphasis

Capitalisation for an utterance or part thereof that is louder than the surrounding talk

((…)) Utterance that is the researcher's comment

(…) No hearing is achieved for the string of talk

↓ indicating a fall in the tone of voice

… Indicate ellipsis, parts omitted in a quotation

? Indicating a question/request

! Indicating surprise

°°° °°° Utterance spoken slightly lower than surrounding speech

Dr. + A, B, C and D: Doctor Identification

D: Doctor

P: Patient

P1 Patient 1

P2 Patient 2

It should be noted that in my transcription the symbols depict only details of communicative features that are perceivable in the recordings and which are relevant to the research questions. They also present evidence of non-verbal noises, most of which are indicated in the researcher's comment ((…)), and some of which have some linguistic significance and relevance to the talk underway. The non-verbal features of the consultation are generally not included in the analysis because they were not the focus of the study. The analysis is therefore mostly done from the DA and CA perspectives but to the exclusion of the micro details usually explored in CA. These two theories each in their own way provide the tools that enable the understanding of the linguistic features and communicative strategies that characterise doctors' and patients' talk during consultation in an inter-cultural context like the clinic. The interactional socio-linguistic dimension of DA is relevant to this analysis as it allows the researcher to divide the speech of the participants into small units such as story-telling, questioning and other affiliative discourse strategies which can be described in the same way (Cordella 2004) as oral genres. In this way, the conversation is linked to the broader sociological context, which assists in discovering the effects. Meanwhile, the CA perspective is restricted to the systematic description of the sequencing and how certain conversational rules are followed to promote order in the interaction which is the consultation in this case. However, the details from the micro perspective that usually characterises micro analysis from CA transcripts are not included here because they are not relevant to the research questions. In using the CA and DA analytic devices, attention is specifically directed at possible uses that can be

ascribed to the fact that the consultation is conducted in ELF. Through-out the researcher had to be alert to features that may be typical of ELF use, in the sense that they would perhaps not be used in interactions between first language speakers of one language, or where an intermediary (such as an interpreter) is engaged

4.7 Summary

This chapter has identified the research design of the study. It focuses on the qualitative nature of the research highlighting the characteristic features of such a study. The chapter points out both the strengths and weaknesses of qualitative research and explains why the approach is suitable for the study. In this chapter, I identify audio-recording as the specific method that has been used to collect data and have provided a list of the transcription symbols used to get the data required to answer the research questions I set out with. I give a description of the recording process to give readers and other researchers an idea of what the field work entails. Furthermore, I describe the participants and highlight the inclusion criterion that was used to recruit participants in the study: the doctors did not have to share a common L1 with their patients and had to use ELF for consultation. Then I mentioned particulars with regard to the numbers of participants and location of the research sites and the procedures involved with ethical clearance which in this case, due to the particularly sensitive context, was a lengthy process.

CHAPTER FIVE
DATA ANALYSIS AND DISCUSSION

5.1 Introduction

This chapter presents and discusses selected extracts from the data corpus which reveal distinctive linguistic and conversational features of HIV/AIDS consultations in ELF in the different clinics that were visited during the course of the study. The chapter begins with an analysis of doctor-patient interaction from the CA and DA perspectives. The researcher identifies the different linguistic and discursive features and communicative strategies that characterize HIV/AIDS consultations and highlights the way in which ELF functions in mediating towards achieving the communicative aims in this particular context. The organisational structures of turns and sequences in the various phases of the consultations are investigated with particular attention to how ELF may have a determining influence on the interactants' management of such turns and sequences. Attention also goes to the features of cross-cultural communication that typify lingua franca communication in this context. The discussion further focuses on repair strategies used for signalling and resolving any misunderstanding that occurs in the consultation. This is followed by a discussion on the different genres that constitute the consultation as evident in the data, be they stories, frames or interviews. This is done to illustrate how the different genres enhance the ongoing interaction and enable the interactants better communicate with and understand each other. Finally, relating insights from the literature to the data, the researcher will indicate how HIV/AIDS consultations reveal a mix of oral genres and how the discourse itself has changed from when HIV was first discovered in the 1980s till date.

5.2 A CA-perspective on linguistic features that characterise doctor-patient HIV/AIDS consultations

In this section I identify and describe some of the linguistic features that are often investigated in CA in order to show the organisational patterns and functions of these features in the HIV consultations to which this study had access. I also discuss ELF features that appear to be marked here, and reflect on the impact of the necessary reliance on a lingua franca in the context of these consultations. As mentioned in Chapter 4, the CA analyses in this study do not explore the detail in phonetic and phonological units of the interaction because these are not relevant to the research questions. Consequently, I focus on describing typical features of conversational structure such as turns, sequences and repair.

5.2.1 Turns and their allocation patterns

Turns are usually analysed in terms of turn size or talking time with regard to turn allocation as to who initiates a turn and how often this is done, the turn type and the allocation pattern (Ten Have 1999: 166). This type of analysis could lead to the exploration of the power dynamic in the interaction, as length of turns and patterns of interruption are often indicative of power hierarchies. I bear in mind that between doctors and patients there is a natural and expected hierarchy in medical knowledge and in familiarity with the clinic routines. The ways in which the physical, social and emotional fragility of patients may limit their power to assert themselves and contribute to decision making where it would be reasonable, has been topicalised in various studies (Mishler 1984; Beisecker 1990; Bensing 1991; Orr 1996; Cordella 2004; Ellis 2004; Moa 2005; Heritage & Maynard 2006). The power dynamic in doctor-patient interactions is not the main focus of this study and is not a primary concern of CA researchers. Rather, it is an issue that is and has been extensively investigated in critical discourse analysis (CDA) (see Beisecker 1990; Wodak & Meyer 2001; Ainsworth-Vaughn 1998).

Regarding the ways in which turn organisation indicates power and control, Spender (1980: 41-47) discusses the issues associated with male dominance in spoken interactions. He points out that men have more rights when it comes to using language as a system than women do since it is normal for them to use interruption as a mechanism to prevent females from talking and to gain the floor for themselves (Spender 1980: 44).Turn time therefore becomes an indicator of power since speaking is usually associated with having something to say, being knowledgeable, having people's attention and being heard even though this is not the kind of power dynamic that operates within the consultations in this study . However, refusing to talk sometimes may also be a means of exercising power and control, as indicated in the male-female interactions reported in some research (see Tannen 1984). In the context of this study, the frequency of turn-taking and duration of the turn is an indication of control and power and it is usually in favour of the doctors whether they are male or female. But this control is shared and is never absolute because it is constantly negotiated between the doctor and patient as each of them takes control of the consultation depending on what is actually happening at different stages of the consultation. The turns of both participants in the consultations are usually shorter at the beginning and at the end of the consultation because the participants are either still settling into the routine or bidding their goodbyes. When the consultation is properly underway and the conversation turns to history and prescription, the turns are longer. With regard to the number of turns per consultation in this study, the general impression is that they are equally shared because there is no instance where any of the interactants refuses to take a turn

even if this is just to respond with a sound or mumble something. But the more proficient both interactants are in English, the more turns they take, the more verbose they are and the longer the consultation itself becomes. The amount of control an interactant has in these consultations can be deduced from the length of time they take to execute their turn. In some cases, the length of the consultation can also be influenced by the gravity of the patient's particular case. For example, Consultation 10 has the fewest turns and is the shortest of all the consultations recorded (taking only 01. 32 minutes). This is because the interactants are not engaged in any disease-related doctor-patient conversation, but are just signing off a document which the patient needs. In contrast, Consultations 3, 11 and 14 are the longest consultations with a single patient, lasting (17.51), (28.09) and (16.50) minutes respectively. In all the recorded consultations, the longest turn of a patient lasts (0.06 minutes) and the doctor's longest turn lasts (0.09 minutes), meanwhile both doctor and patient have several single-word turns. The rest of the turns in these consultations are almost evenly distributed in terms of size with both doctors and patients alternating with single TCUs.

The turn distribution in all the consultations recorded in this study reduces the regular incidence of doctor control and power asymmetry that characterizes medical consultations reported elsewhere (see Beisecker 1990; Orr 1996; Cordella 2004; Moa 2005; Heritage & Maynard 2006). This is why the consultations generally look almost like a friendly conversation. The degree of control is determined by how long an interactant holds and how often s/he takes the floor. Different communication situations and genres influence turn time. In the particular consultations here, although the doctors initiate more turns than the patients, turn time varies as the consultation progresses. The patient and the doctor each have more turn time during the history-giving and the prescription-instruction-giving phases respectively. This concurs with findings of earlier research (Sacks et al. 1974, Boxer 1992 & Wooffitt 2005), which indicate that the structure of turns varies depending on the conversation phases and the interlocutors involved.

The HIV/AIDS consultations in this study are characterized by initial shorter turns of question-answer adjacency pairs, initiated mostly by the doctor (see *Consultation 1)* and sometimes by the patient (see *Consultations 2, 4,* & *8*, discussed in section 5.4.1 below). The turns gradually become longer and more elaborate, depending on what phase the consultation is at, and which interlocutor is expected to contribute more on the topic at hand. But generally, possibly because the doctors are more proficient in ELF than most of their patients and more informed on the illness, the doctors' turns are more elaborate, explicit and more frequent than those of the patients. Consequently, doctors as expected, still exert a lot of control over the interaction. Also, contrary to the power

dynamic in male-female interactions mentioned earlier, the power play in these HIV/AIDS consultations is different in that all the doctors, regardless of whether they are male or female exert control in the interaction by initiating more turns irrespective of the gender of the patient.

Turn allocation patterns are suited to particular communication acts and turn types. Sacks et al. (1974) and Wooffitt's (2005) research highlight two turn-taking patterns in conversation regardless of whether the interaction is in ELF or not. They are: the 'one speaker speaks at a time' and the 'recurrence of speakership'. Their studies discuss the rules that interactants unconsciously observe in conversation in order to observe these turn-taking patterns (see Boxer 1992). Regarding the turn-allocation techniques, the interactants in the HIV/AIDS consultations often respect the 'one-speaker-speaks-at-a-time' and 'recurrence of speakership' patterns, even though there are few instances of simultaneous talk and overlap during the interactions. The turn-taking patterns in the HIV/AIDS consultations conform to those in doctor-patient consultations in other illnesses with the doctor always claiming the floor first (Todd & Fisher 1993). When interlocutors negotiate their turns expanding and discussing a particular topic, topic change is expected as the consultation progresses and turn allocation patterns too are modified depending on the number of interactants involved and who pre-/self selects.

Due to the nature of the HIV/AIDS medical condition that requires a lot of emotional and physical support for the patients, the patients are sometimes accompanied by someone to the consultation, as in the particular Consultations mentioned below. The turn allocation pattern is modified in these cases and negotiated to accommodate three or more interlocutors, two of whom are the doctor and the patient and then in mediated cases, there are contributions from the nursing sister, or the spouse of the patient. The rules of selection and pre-selection when there are more than two participants are illustrated in the data as follows: one consultation involves the doctor, a husband and wife (*see Consultation 15*), nine involve the doctor, patient and a nursing sister(see *Consultations 4, 5, 7, 8, 11, 12, 13, 14 &17)*, and nine involve the doctor and patient alone *(*see *Consultations 1, 2, 3, 6, 9, 10, 16, 18 & 19)*. A third party in the consultation significantly impacts on the interaction, especially on the flow of the consultation.

The 'third party' individuals who join the consultation play different roles in the interaction and also play a vital role in turn introduction. In such situations where there are more than two interactants, the application of the rules governing the turn-taking patterns can disrupt the interaction and may introduce unwarranted interruptions. The present speaker may select a next speaker to avoid a chaotic struggle for taking and holding the floor. Interestingly, the interactants in

this study apply these turn-taking and turn-transition rules as illustrated in the extracts given below, but also use other strategies such as code-switching to a particular L1 (to be discussed later), to select and identify the next speaker. In Extract 01 *(taken from Consultation 1)*, the pattern indicates that one speaker is speaking at a time and that speakership is recurring with the series of questions and answers from lines *27-34*. Doctor A wants to know if the patient had done the TB test besides the obvious HIV test indicated by the words '…as well' (*line 27)*. Doctor A's line of questioning and especially the question in *line 33* indicates her apprehension about the deteriorating health of the patient as she draws his attention to the '…white things on your tongue' which could indicate that his HIV has advanced to stage 3 (*line 35*).

Extract 01: Illustrating one-speaker at a time and recurrence of speakership

27	Doctor A:	Did you test for TB as well?
28	Patient:	Yes
29	Doctor A:	When was your test?
30	Patient:	Two or three years
31	Doctor A:	And now are you having any pain or irritation when eating?
32	Patient:	No
33	Doctor A:	Ok did you notice there is white things on your tongue?
34	Patient:	Yes
35	Doctor A:	Ok it doesn't look like thrush but it looks like what we call oral hairy (mucoplachae). It is a complicated name but it tells me that you are stage 3.
36	Patient:	Uhmm!

Extract 1, shows evidence of interactants' ability to project the turn transition relevance point from the cue that is signalled by the rising voice tone, marking the end of each question that represents a turn construction unit (TCU) and the content of the response to the questions. At this point, speaker change is expected and possible since a response is expected and so, the rules of selection set in whereby the current speaker could continue to speak if the next speaker is not selected or doesn't self-select. But in this case, the rule of pre-selection (Boxer 1992) is applied in that the doctor indicates the end of her turn by selecting the patient with the reference 'you', making it absolutely clear that the patient had the right to the floor. In this way, the patient and the doctor alternately self-select in the question-answer pairs. This makes it possible for one person to speak at a time and for the interaction to progress in a particular way. The patient's responses to the doctor's questions indicate acknowledgement and listenership of the other participant and the purpose of the

interaction at this point is for the doctor to get the crucial piece of information about the TB test in order to make a proper diagnosis.

In most of the opening turns between the doctors and the patients, one gets the impression that the doctor is almost obligated to claim the floor and initiate the first turn which is usually a greeting, a welcome that sometimes goes with an identification of the patient by name as evident in Extract 02 below (*taken from Consultation 4* **)**. When the doctor says '*Hello R…' (line 1),* she identifies the patient by name and pre-selects him for the next turn. This identification in itself indicates a degree of familiarity with the patient and the fact that there is an already existing relationship which ensures confidence and facilitates communication between the interlocutors. But the rule of 'one speaker speaks at a time' is not so water tight as to eliminate the possibility of simultaneous speech, a feature which could be interruptive or consensus and solidarity-oriented. This is evident as the doctor is trying to establish when the patient started the ARV treatment (*Extract 02).* From the response that results in the simultaneous speech in lines 15 and 16 (from *Consultation 4),* it is clear that both doctor and patient are doing their calculations backwards from the time of the consultation (*line 14*) to get to the exact month in which this happened. This leads them to the month of October of the previous year (*lines 15* and *16*). Such instances of simultaneous speech do not flout the rule of 'one speaker speaks at a time' in a disruptive way. Rather, it is an example of a case where both interlocutors are jointly and collaboratively involved and responsible for the interactional order which is the outcome of the interactional process resulting from their understanding of each other's behaviour (Atkinson & Heritage 1984). Therefore, the overlap here is supportive in that the doctor correctly predicts the patient's response. However, the doctor is the one who reclaims the floor immediately after this to introduce a new topic.

Extract 02: Indicating simultaneous speech

9	Doctor B:	Hello, how're you?
10	Patient:	I'm fine, Sisi
11	Doctor B:	How long are you on treatment?
12	Patient:	Since I was start errh treatment I don't have a problem
13	Doctor B:	How long are you on treatment?
14	Patient:	Fi::ve months now.
15	Doctor B:	[Since October last year]
16	Patient:	[Yes, since October last year]
17	Doctor B:	No problems?
18	Patient:	No problems, doctor

The institutional setting of the HIV/AIDS consultation gives room to frequent interruptions in the flow of the consultation and disrupts the turn-taking pattern in the consultation. These interruptions are caused by the sudden and unexpected opening and closing of doors either by the doctor to request some clarification from the nursing sister or the nurse coming into the consultation room to give some records or test results. In Extract 03 (*Consultation 14*) below for example, Doctor C is trying to establish if the patient was given information about the CD4 and the viral load *(lines 107 & 109*). When the patient acknowledges that she was informed about the CD4 (*line 112*), she is cut-off by the doctor's praise *"Good and things"* (*line 113*). Then, just when the patient claims the floor again to respond to the question about her knowledge of the viral load there is a sudden interruption with the opening of the door and the nursing sister enters. The patient's turn is thus suspended mid-way as the nursing sister at the beginning engages the doctor in conversation to the exclusion of the patient who before her entry was holding the floor (*lines 114-119*). As the doctor and nursing sister try to decide from which IDC the patient was referred, the patient cuts in and interrupts to provide the information *(line 120)*. The nursing sister thanks the doctor and leaves banging the door behind her causing more interruption (*lines 122-123*). It is only after this that the patient and the doctor return to the issues they were discussing before the nursing sister came in and the patient reclaims the floor to finish what she had been saying, *"Yes she told me my CD4 count is 344" (line 124)* and *"That's great and the viral load?" (line 125)*. The consultation then continues normally with the doctor providing the information the patient lacks about the viral load *(line 127)*.

Extract 03: Interruptions due to the institutional setting

105	Doctor C:	And you are now on treatment for one year neh?
106	Patient:	Yes doctor
107	Doctor C:	Did Sister M discuss your viral load with you?
108	Patient:	No::
109	Doctor C:	And your CD4?
110	Patient:	Yes with my CD4 count
111	Doctor C:	Yeah, yeah
112	Patient:	She did tell me about my CD4 count, it's a little bit
113	Doctor C:	Good and things
114	Patient:	Yes ((opening of door))
115	Doctor C:	Sorry Sister
116	Nursing Sister:	Ehmm doctor, H is from IDC on antiviral drugs
117	Doctor C:	Yeah?
118	Nursing Sister:	( )

119	Doctor C:	Ok. Is it is it, did they have the err just ask Sister to give us from which IDC
120	Patient:	Your ((name of town)) TC Newman
121	Doctor C:	TC ok. You can just put it in the (name of town)) TC ok?
122	Nursing Sister:	Thank you doctor
123	Doctor C:	Ok errhm ((bang of door))
124	Patient:	Yes she told me my CD4 count is 344
125	Doctor C:	That's great and the viral load?
126	Patient:	She didn't tell me about the viral load
127	Doctor C:	The viral load is beyond detectable levels

Sometimes the interruptions are caused by the doctor making a call to another facility to get more information about the patient as seen in Consultation 11. Doctor A first interrupts the consultation as she rushes out to verify information from the patient's file in another health facility by phone *(line 80),* and does it again when she (the doctor) interrupts the explanation she is giving to the patient on the drugs she (the patient) was given as she says *"I must quickly go and phone ((opening and shutting of door)) ((door opens and slams shut)). Sweety, when did you go to (name of town)? Which date did you go to ((name of town))?" (line84).* The consultation then resumes after the said telephone call had been made but could not be successfully concluded because the patient was unable to adequately provide answers to the doctor's questions. This inability of the patient to express herself in itself was a major cause of interruption in the flow of the consultation and could be attributed to the patient's limited level of proficiency in ELF. Furthermore interruptions are caused by the doctor during a physical examination on the patient. All of these aspects affect the flow of the consultation, sometimes resulting in stretches of silences, language switching and linguistic interference, banging of doors and the screeching of some medical equipment, all of which are quite obvious in the recordings in this research.

5.2.2 General sequence structure in communication and medical interactions

It was indicated earlier (see *section 3.3.1.1*), that sequences and turns are intertwined and yet they are different. Sequences comprise turns deployed as actions, which in themselves reveal a complex temporal and progressive ordering in interaction (Todd 1993). A single sequence can have more than one turn and there is an indication that certain specific action types are relevant at specific recognisably unfolding sequences. This explains why it is highly unlikely that one would find a 'goodbye-turn' for example in an opening sequence or a 'hello or how are you-turn' in a closing

sequence. The production of a turn involves an ordered progression through a verbally structured action and the operation of turn-taking depends on an ordering of speaking opportunities in the sequence. There are a number of regularly occurring sequences (such as openings and closings) that mark most conversational exchanges, and then a number of them that regularly occurred in the data for this study. For example, in medical consultations the opening and greeting sequences as well as the prescription and instruction-giving sequences offer more speaking opportunities to the doctor whereas the patient speaks more in the history-taking sequences. The sequences in the HIV/AIDS consultations for the present study like those in other medical interviews contain distinct openings, closings and transitions between topics (Todd & Fisher 1993: 27) with the doctor initiating and directing the interaction. This type of sequential organization is characteristic to all forms of communication. However, the occurrence and organisation of some sequence types is typical of medical consultation, and even more specifically of HIV-consultations recorded for this study as below. But this is not a typical characteristic of ELF use.

Research on the organisational structure of sequences in discourse analysis revealed a two-part structure in conversation between equal partners in everyday settings (Sacks et al. 1974), whereas dialogue in institutional settings is organised differently (Todd & Fisher 1993) because of the purpose and audience involved. For instance, in medical interviews where the discourse takes place in an institutional setting in which the doctors have power as experts (Ainsworth-Vaughn 2001), the patient's participation in this form of structured question and answer interchange is constrained resulting in sequences that are doctor-centred, and that display a dialectic relationship between the discourse and the organisation (Todd & Fisher 1993: 188-89). In the medical setting as in other institutional settings such as the courtroom and classroom, the asymmetry between the participants, results in the production of a third part in the sequence structure which is the evaluation (see Todd 1993: 189). In the medical consultation, the third part is referred to as the reactive (R) which is either the doctor's reply or the doctor's acknowledgement. It is used by the doctor in a turn to maintain the floor after the patient's response. The doctor initiates a request for information and the patient's reply to his/her question is acknowledged with a reactive (Todd 1993: 189). This sequential organisation is represented in figure 1.

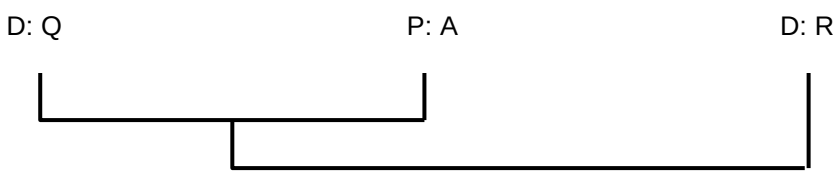

Figure 1: The three-part structure of interaction (Todd & Fisher 1993: 189).

This shows that when the doctor initiates the interaction with a question s/he ultimately controls the topics discussed because the patient has to respond. The reactive then serves to end the patient's interactional segment and then returns control of the interaction to the doctor, giving him/her the opportunity to end a particular frame or topic and introduce a new one. Figure 2 is an example of such a sequential structure found in the present study (taken from *Consultation 4),* which illustrates the function of the reactive. The doctor's reactive "you're feeling ok today" is a statement that both acknowledges the patient's reply and enables the doctor to verify what the patient said. It allows the doctor to introduce a new topic which she does when she asks when the patient recommenced his treatment. The patient's contribution displays a reactive in a single-speech-act turn which is in contrast to the elaborate comments displayed in the doctor's turns. The patient often uses a reactive as both the initiation and end of his/her turn and usually in response to the doctor's utterance (Todd 1993). This is why patients usually do not utter a reactive and continue the interaction, whereas the doctors do so and even introduce new topics. This kind of control reveals subtle organisational and interactional influences on discourse, which in turn inevitably enhance the manifestation of the medical institutional power.

Initiation	**Reply**	**Acknowledgement**
D:Q	**P:A**	**D:R**
Are you fine? Are you feeling better today?	Yeah, I'm feeling errh I'm feeling ok	You're feeling ok today. When did we restart actually? Was it last time or, or when did you start AGAIN? You remember you: came back from (Name of country) and errh

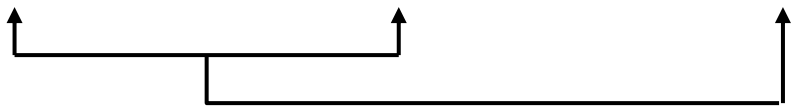

Figure 2: Diagram of a doctor-patient interaction during an HIV/AIDS consultation

The different sequences in the HIV/AIDS consultations have certain characteristic features which are apparently typical of medical consultations generally. The present study reveals the presence of different types of sequence markings, spanning the various phases of the consultation, starting with the opening and greeting sequences, the information-seeking sequences which typify the history-taking phase, the physical examination sequences, the prescription and instruction-giving and the closing or goodbye sequences. These sequences are present in all the consultations but not in any particular order; various consultations have different sequence orderings within the same sequence

type, due to differences in content, and depending on the specific doctor and patient involved. Specific structures and sequences occur repeatedly throughout the data corpus. The analysis of some of the sequences that are identified in the consultations as well as their thematic content reveals how in some ELF communication, HIV/AIDS is topicalised.

5.2.2.1 The opening and greeting sequence

Firstly, the opening and greeting sequence in the consultation usually begins with some verbal interchange between the doctor and patient and in a few instances the researcher is present and takes part in this as well. The doctor greets and sometimes explains the purpose of the recording and makes sure that the patient granted voluntary and informed consent. The doctor also sometimes reassures the patient of the anonymity clause in the Consent Form *(*see *line 5, Consultation 8)* "*Yeah but we won't put your name on the system and things like that"* and (*lines 1 & 3, Consultation 3) "So you're happy, I'm just going to say it again so it's on the recording. So you are happy to continue with the recording"* This sequence reveals the doctor's level of familiarity with the communicative context because usually the doctor gives this explanation making it obvious that s/he is only part of a concerted system to ensure obtaining informed consent. This shows that the doctor makes sure that the patient is fully aware of the implications of the recording. This type of opening sequence occurs in 8 of the 19 consultations. Although the doctors can see from the patients' copies of the signed consent forms that proper ethical procedures have been followed, they need to confirm this on record at the very beginning. This explanatory sequence is important to the study because it is an ethical requirement, but it does not really constitute part of the consultation itself. It functions to prepare the patient and establishes confidence between the interactants, making the consultation relaxed and cordial.

The greeting sequence is one of the most frequent in the doctor-patient interactions in the present study and they reveal a lot about the generic structure of such communicative encounters in institutional settings as will be illustrated later in genre theory (section 5.4). It occurs in 12 of the 19 recorded consultations and is typified by the *'hello'*, '*hi*' or *'how-are-you'* question and answer pairs. The greeting sequence itself sometimes contains the direct identification of the patient by their names, which are replaced with a code because there is a conscious effort on the part of the researcher to keep the participants anonymous. The identification by name indicates a level of familiarity between participants and establishes a good and trusting working relationship between the interlocutors and might well be as some research points out, a means for the doctor to make sure s/he is consulting the right patient (Watermeyer 2008; Penn 2007: 2057). This does not occur in all

the consultations but happens at least once with each of the doctors across the data corpus. This is an indication that some of the patients were not meeting these doctors for the first time as seen in 'Hello R, how are you?'*(line 1, Consultation 5)*. Although this sequence is used to establish familiarity and a relaxed environment, the greeting sequence is conspicuously absent from Doctor A's consultations. This in no way indicates a lack of friendliness and caring on the doctor's part, but could simply be a peculiarity in the individual's approach. The communicative strategies that characterise the greeting sequence are often polite and almost perfunctory in nature (see *Extract 04,* taken from *Consultation 7),* a view that has been shared by Watermeyer and Penn (2009). The initial turns in these sequences are usually initiated by the doctors but the next turn sometimes is unpredictable. In Extract 03 for example, the doctor's '*ok*' response-turn is followed by an immediate topic change *(line 3)* in response to the patient's *'I'm fine' (line 2)* indicating that the state of health of the patient is not the primary focus of the interaction at this point. Instead the doctor is more interested in getting the patient started on ARVs *(line 3)* and to ascertain the patient's readiness with the repeated questions in lines 5 and 7.

Extract 04: The regular greeting sequence

1	Doctor B:	Hi, how are you?
2	Patient:	I'm fine
3	Doctor B:	Ok are you ready to start treatment today? Are you ready to start with your ARVs today?
4	Patient:	Today
5	Doctor B:	Are you ready?
6	Patient:	Yes
7	Doctor B:	Are you?
8	Patient:	Yeah

Some of the greeting sequences include an expression of interest on the part of the doctor in the patient's state of health. In Extract 05 *(*see *Consultation 5)* for example, Doctor B seems particularly concerned about the fact that the patient had broken off treatment earlier. Usually such non-adherence exposes patients to the risk of not responding positively to the ARVs or worse still developing resistance to the treatment. So the doctor asks for confirmation of good health from the patient in line 3, which the patient gives in line 4. The doctor's repetition of the patient's response in line 5 is a linguistic strategy she uses to verify and confirm what the patient said in lines 2 and 4. This has been identified as a typical feature in ELF interactions (Mauranen 2006: 136). This kind of confirmation check gives reassurance and enables the doctor to carry on with the discussion, which

she does by initiating a topic change with, *"when did we restart actually? Was it last time or, or when did you start again?" (line 5).*

Extract 05: Doctor's concern about patient's health

1	Doctor B:	Hello R, how are you?
2	Patient:	I'm fine
3	Doctor B:	Are you fine? Are you feeling better today?
4	Patient:	Yeah, I'm feeling, errh I'm feeling ok
5	Doctor B:	You're feeling ok today. When did we restart actually? Was it last time or, or when did you start AGAIN? You remember you: came back from ((name of country)) and errh
6	Nursing Sister:	Oh yes, ye:s, exactly
7	Doctor B:	Oh in January already, so it's already like two months?

5.2.2.2 The information-seeking and giving sequences

These sequences come after the greeting sequences and feature the question-answer pattern of the opening sequence. At this stage of the consultation, the dialogue reveals a focus on the HIV/AIDS content as well as the use of certain ELF features in terms of the lexical and syntactic structure of the interaction as the doctors enquire about the state of health of the patients. The doctor would ask questions about whether or not the patient is already on ARVs and for how long and basically gets the medical history of the patient from the medical records and the confirmation of the records from interacting with the patient and the nursing sister.

The lexical content of these sequences highlights some of the features that are characteristic of ELF and peculiar to South Africa. This is discussed more elaborately later in sections 5.3.1.2 and 5.3.2.3. Within this sequence the doctor also tries to get information about how the patient is coping with the treatment by checking adherence and verifying the time at which the patient takes the pills *(*see *lines 9-23 of Consultation 6*). This is a very crucial aspect of HIV/AIDS treatment that is recurrent in the consultations. It is important for the doctor to know how long the patient has been on a particular regimen of treatment in order to determine how much progress s/he has made on the regimen. This is a regular sequence in HIV/AIDS consultations, namely the regular surveillance of how HIV/AIDS patients are coping with their treatment. In Extract 04, Doctor B first gets confirmation that the patient is feeling well (*line 4),* and then establishes how long the patient has

been on treatment *(line 7)* This will help to determine whether the medication has had negative side-effects, and if not, that the patient is settling in to the use of the prescribed drugs.

5.2.2.3 The physical examination sequence

The doctors and patients use their turns and sequences to perform various tasks. The analyses of the consultations in the present study show that in the course of the some of them it is sometimes necessary for the doctor to perform a physical examination on the patient. Such a sequence is usually patient-centred because even though it describes the activities of the doctor as well as what s/he says, the patient and his/her physical condition is in focus as the doctor wants to check that the patient is physically ok, and if not, to advise and treat. But the doctor verbally tells the patient what his/her intention is and requests for a specific reaction. In such a sequence the patient gets the cues from what the doctor says (see *line 95, Extract 06,* taken from *Consultation 7*) and gets ready for the physical examination. Of all the sequences in the consultation this is the one that illustrates the medical nature of the encounter the most as it reveals that the interaction is undertaken in a medical space. This is evident in the presence of medical equipment.

Extract 06: A physical examination sequence in the HIV/AIDS consultation

77	Doctor B:	Ok, but are you having any problems at the moment?
78	Patient:	Agh
79	Doctor B:	Are you feeling well?
80	Patient:	But I'm just developing some spots
81	Doctor B:	Uhmm,
82	Patient:	Spots like errh
83	Doctor B:	But you're not on TB treatment neh? TB treatment, you are not on TB treatment?
84	Patient:	Yes
85	Doctor B:	You're not
86	Patient:	No, I'm not
87	Doctor B:	Have you ever been on TB treatment?
88	Patient:	No
89	Doctor B:	No ok. You are not coughing?
90	Patient:	No
91	Doctor B:	You are not sweating at night?
92	Patient:	Yes

93	Doctor B:	You are not allergic to any medication neh?
94	Patient:	No I'm not
95	Doctor B:	Ok let me just have a look at you quickly. Show me your spots
96	Patient:	Here
97	Doctor B:	Just in the head neh?
98	Patient:	Yeah in the head
99	Doctor B:	Just sit here, sit here. Take off your jacket quickly
100	Patient:	((Ruffle of clothes))
101	Doctor B:	Let me listen to your chest. Nice deep breathe (guess)
102	Patient:	((Breathes))
103	Doctor B:	Again
104	Patient:	((Breathes))

When Doctor B enquires from the patient "are you feeling well?" (*line 79*), the patient's response is hesitant and presents a problem: "*But I'm just developing some spots"* (*line 80)* which gives a basis for the physical examination. The doctor's "*Uhmm*" (*line 81*) is like the 'yes?' in NS usage which is a form of prompting and permission for the patient to continue the conversation and give more information about the 'spots' he is complaining about. Rather than giving a description of the spots (*line 82*), the patient shows them to the doctor who then takes the floor. What may seem to be a change in the topic is in fact an indication that the doctor is checking for possible complications such as allergy to TB treatment or any other medication (*lines 83, 87, 91*). This cross-examination of the patients on their response to treatment cuts across many of the consultations and is in itself a typical characteristic of HIV/AIDS consultations and treatment. The topic change is the doctor's strategy to avoid dealing with the unsatisfactory attempt at describing the spots by the patient but could illustrate how gesture and other non-verbal means of communication can be used when ELF speakers do not quite know how to explain symptoms. This may seem contradictory but supports reports that one way by which ELF speakers deal with misunderstanding in a non-verbal manner is by changing the topic (Mauranen 2006: 143). But due to this failed explanation the doctor requests for a physical examination (*line 95*). From the ensuing interaction the doctor seems to be concerned about the problem that the patient raised. After looking at the area indicated by the patient's "here" (*line 96*), she requests the patient to take off his clothes (*line 99*), to which the patient responds (indicated by the ruffle of the clothes being pulled off *(line 100)*. So she makes another request for the patient to take off his clothes (*line 99*), to which the patient responds (indicated by the ruffle of the clothes being pulled off *(line 100).* It is clear from the conversation that follows that the doctor

wants to consider all the possible causes of the spots before embarking on a full scale treatment as is often the case with the AIDS disease.

Extract 06 has some very interesting sociolinguistic and pragmatic markers which often occur in ELF interaction. In line 78 for instance, the utterance '*agh*' is neither a clear 'yes' or 'no' but can be compared to the NS '*well*'. It is common in lingua franca communications to find speakers responding to a negative-tag question with a 'yes' when they actually mean to say 'no'. This type of response behaviour is characteristic in local languages such as Xhosa and thus could be considered a localised feature of the interactants concerned. For example, the doctor asks, "*TB treatment, you are not on TB treatment*?" and the patient replies, "*yes*" when he really means that he is not on TB treatment. The same thing happens (*lines 91 & 92*) when the doctor asks, "*You are not sweating at night*?" and the patient answers, "*yes*", meaning "Yes, your implied statement is right".

5.2.2.4 The prescription and instruction-giving sequence

After the physical examination sequence, the prescription and instruction-giving sequence follows, in which the doctor usually goes through all the different types of medication that have been prescribed for the patient one by one, explaining how they are used. This sequence is always initiated by the doctor and devoted to informing, advising and educating the patients on their medication and dosage instructions as seen in all the consultations. At this stage of the consultation the doctor may decide to change an ARV regimen depending on the patient's history with the ARVs or give dosage instructions for new medication. The doctor also reminds the patient of these instructions and draws his/her attention to any changes in the medication that could confuse the patient particularly if the physical appearance of the medication has changed due to new packaging (see *line 121* of *Extract 07,* taken from *Consultation 11*). The doctors use various discourse strategies in these sequences such as demonstrating aspects of method of using the medication and detailed explanation. This is to ensure and verify that the patient understands the dosage instructions because this is crucial to the success of the treatment. These sequences often include requests for clarification or self-repair by doctors *(Extract 07, Consultation 11).*

Extract 07: The instruction-giving sequence

113	Doctor A:	Can you bring the card along next time?
114	Patient:	Yes

115	Doctor A:	(0.17) because otherwise it's very difficult to find out what they found or anything (guess) (0.30) Ok, alright (ruffle of paper) I'm repeating all those tablets and this is your D4t hey? (guess)
116	Patient:	Yes
117	Doctor A:	Ok this one, where are your old tablets let me show you
118	Patient:	((rattle of medicine bottles and tablets on the table))
119	Doctor A:	I see that ( ). Ok so that is the same hey?
120	Patient:	Yes
121	Doctor A:	Alright? Ok this one oh (chuckles) they've changed it alright? This is the same ok. I'm just gonna I know it's, this is I know it's confusing. This one is brown now okay. I'm just gonna mark it D4t can you read it?
122	Patient:	Yes
123	Doctor A:	(02.1) Ok just take that to Sister B okay, because I want r just I want her to errhm phone about the ( ). Oka:y.

The doctor physically picks up the different medications one by one to make sure the patient is able to identify each one of them (*lines 116, 118* & *120*). The patient gives approval with a minimal '*yes*' (*lines117* & *121*). As expected, the doctor is quick to notice the change in one of the drugs and points this out to the patient (*line 122*). The doctor is constantly checking for patient's understanding by asking questions (*lines116, 120* & *122*) which are all followed by a '*yes*' response. Normally these dosage instructions and clarifications are supposed to be given by the pharmacist but in some of the follow-up consultations, the nursing sister brings the medication to the consultation room and the doctors give the instructions themselves. It is not clear from the consultations why this is done. This indicates that there is a degree of flexibility in the performance of some aspects of the consultation. There is no single prescribed participant who is assigned the role of explaining how medication is to be used. The doctor can elect to do so; alternatively, s/he can assign this particular sequence to the nursing sister who will see the patient after the consultation with the doctor

5.2.2.5 The closing sequence

The closing sequence has been referred to as close implicature (Watermeyer et al. 2009: 2065). It is present in all the consultations in the present study and marks the formal endpoint of the interaction.

The closures vary with individual consultations and are usually signalled by expressions of tokens of appreciation or a farewell remark such as '*thanks a lot', 'bye' or 'it was nice seeing you'* from the doctor, followed by an echo of '*bye*' or '*thanks doctor'* from the patient. There are 12 such formal closures out of the 19 consultations in the present study. These types of closures are normal and expected at the end of any consultation (see *Consultations 1, 2, 3, 5, 6, 8, 10, 12, 13, 14, 18, 19*). In Extract 08 (taken from *Consultation 2*)**,** there is an indication that the consultation is over, as the patient's question '*should I give this to Sister M*?' (*line 58*) suggests that she has no complaints and that the doctor does not need her to give any more information than she already has. Therefore, the doctor answers in the affirmative and hands over the tablets, a task which in itself is linguistically significant of the end of the consultation. The consultation is supposed to be over at this point although a new sequence can be initiated, were the patient to come up with another complaint instead of her answer, "*Everything is fine"* (*line 60).* This reply changes the tone of the interaction as the mood becomes lighter and personal with the doctor's responses and indicating satisfaction with the way the consultation has gone '*ok, alright, super. See you then'* (*lines 61*) and ends the consultation by giving her final goodbye in the close implicature, "*Bye Sweety*" (*line 63*)

Extract 08:The close implicature

58	Patient:	Should I give this to Sister M?
59	Doctor A:	Yes, she can give you the tablets, agh, not the tablets the cream. So I just put it here ((ruffle of paper)), here we go, here are your tablets ok. Alright, anything else you wanna ask me?
60	Patient:	Everything is fine
61	Doctor A:	Ok, alright, SUPER. See you then.
62	Patient:	B:y:e
63	Doctor A:	Bye Sweety

In some of the closing sequences there are cases of reclose implicature sequences (Watermeyer & Penn 2009: 2066) whereby after signalling a close implicature, the doctor then returns to a question-answer sequence in which a new topic is initiated or a topic that had been discussed earlier is reintroduced and elaborated upon. This is quite recurrent in the doctor-patient interactions in this study and signal a pattern in the generic structure of such HIV consultations where especially the doctors try to adequately cover all aspects There are 9 of such closures in the corpus (see *Consultations 4, 6, 7, 8, 9, 11, 15, 16, 17,* & *18*). These kinds of closures cannot be accounted for by the competence of the interactants in ELF or lack thereof neither are they a distinct feature of HIV/AIDS consultations alone but are possible occurrences even in other medical interactions. In

Extract 09 (taken from *Consultation 8*) for example, this part of the consultation is centred on the medication. The doctor enquires from the nursing sister if the patient's medication has been brought in and immediately notices that some of them have been changed (*lines 73-75*). The discussion that ensues reveals a characteristic feature of ARV treatment, namely, the need to make sure patients understand both the names and physical appearance of the medication they were taking. Thus the doctor goes through the different types of medication, giving very detailed and specific dosage-instructions and description (*lines 81-97*). After discussing the changes in the patient's medication and agreeing on the date for the next visit, the consultation is formally over (*see lines 97-103*). But the reclose implicature (*line 104*) introduced by the doctor's question in line 103, opens up the discussion again but this time, not on a health related issue rather on a financial concern *"No unless I errh I filed a letter because I was errh getting sick pay, sick pay"* (*line 104*). This is a request that requires the doctor's intervention. If the patient does not have any source of income that will negatively impact on his ability to afford good nutrition and this can have a ripple effect on both the patient's health and ARV treatment. Thus, the sequence continues with the doctor and patient interactionally engaged in working out how to find solutions to the financial predicament, with the doctor giving the patient some useful advice and encouragement. After this is done the doctor reminds the patient of the date of the next visit, followed by the final goodbye and thanks, "*Okay, April 21* (*closing folder*). *Ok P thanks eh? Nice seeing you and we'll see on, nice Easter for you ok we'll see you in April again ok?"* (*line 147*).

Extract 09: The reclose implicature

71	Doctor C:	Sister do we have her treatment here?
72	Nursing Sister:	I think so yes
73	Doctor C:	They have reduced her they have reduced her
74	Patient:	from 40
75	Doctor C:	To 20 ok. We just need to go through your tablets to make sure it's better there (guess) okay?
76	Patient:	Ok
77	Doctor C:	((ruffle of paper))
78	Patient:	It's from Friday to
79	Doctor C:	Agh two weeks. I'll put it in the book. Ok errhm P let's just see, do you have your tablets with you?
80	Patient:	Yes I do
81	Doctor C:	Then we'll just have a look and see what we can change ((crackle of tablets)) Ok so this one let's see, this one is

staying the same ok? The Nevirapine is staying the same.

82 Patient: Yes

83 Doctor C: This one is Lamivudine and this is changing but it's the same one. But you can see we can open it. I'm going to open

84 Patient: Hmm

85 Doctor C: You can see that although it looks like that this is the purple one (guess). It's going to look like this in the future okay?

86 Patient: Ok, alright

87 Doctor C: Okay? That one is that one, it's not the triangle any more

88 Patient: Hmm

89 Doctor C: It's that one. You will see that it's Lamivudine, Lamivudine

90 Patient: Lamivudine, yeah

91 Doctor C: This is like Pick n Pay and this is like Checkers ((chuckles))

91 Patient: ((chuckles))

93 Doctor C: Okay? Now this one is going to change a bit. You see on the one you have 20 and 20.

94 Patient: 20

95 Doctor C: Oh they have already done it

96 Patient: Hmm

97 Doctor C: So this is the smaller one, you take one of them hey? So you know them hey?

98 Patient: Yes I know yes

99 Doctor C: Ok so that's basically perfect

100 Patient: Yes

101 Doctor C: So you have enough tablets

102 Patient: Yes

103 Doctor C: That's enough, any questions?

104 Patient: No unless I errh ((smacking of mouth)) I filed a letter because I was errh getting sick pay, sick pay

105 Doctor C: U::hm sick pay yes?

106 Patient: Yes so I file the letter errh this side

107 Doctor C: Yeah

108 Patient: Mara I've not finished yet to pay. I still have three months

109 Doctor C: Yeah so you will get up till May, you will get it till May

110 Patient: Oh yes

111	Doctor C:	But then after May they are not going to give it longer.
112	Patient:	Alright
113	Doctor C:	So then you need to make a new plan
114	Patient:	Alright
115	Doctor C:	Are you going to have a job or something?
116	Patient:	NO
117	Doctor C:	But what did you think, how can you make money?
118	Patient:	Eish I don't know doctor
119	Doctor C:	Is it? You must think of something ok because they don't give the grant for ever ok?
120	Patient:	Yes doctor
121	Doctor C:	They are just stopping it and things
122	Patient:	Alright
123	Doctor C:	But you look like a clever lady. What work did you do before? Where did you work before?
124	Patient:	I was working at Northern Province to the Sun International
125	Doctor C:	SUN INTERNATIONAL?
126	Patient:	Yes
127	Doctor C:	At SUN CITY?
128	Patient:	At Thohoyandou
129	Doctor C:	Oh that side. What did you do there?
130	Patient:	I was a cleaner in the casino
131	Doctor C:	O: oh ok, ok and did you look for jobs like that here or not?
132	Patient:	I've been looking but I do:n't get it
132	Doctor C:	Do you have a letter from them that you've done the work?
134	Patient:	No
135	Doctor C:	Because I think there's going to be a lot of hotels next year for the soccer and things like that
136	Patient:	Hmm
137	Doctor C:	And these hotels you must go and ask them and say, "can I do that and things". People are doing well on their ARVs and they can have normal jobs and things like that
138	Patient:	Yes yes
139	Doctor C:	And you don't need to feel like you have to tell people about the HIV

140	Patient:	Alright yes
141	Doctor C:	Ok if you are doing good as you are doing we will make it that in future that you will only need to be here every second month and things like that ok?
142	Patient:	Hmm
143	Doctor C:	So she has still treatment for 9, 15, 9, so that means she has still another week's treatment. So she can come either 4 weeks or 5 weeks
144	Nursing Sister:	Eegh 4 weeks
145	Doctor C:	Four weeks. You can give the red thing if you want to and work out her system. M would do that with other patients I think (guess)
146	Nursing Sister:	21 April
147	Doctor C:	Okay April 21(Closing folder) Ok P thanks eh? Nice seeing you and we'll see on- nice Easter for you ok, we'll see you in April again ok?
148	Patient:	Ok
149	Doctor C:	And see if you can get a job then. See what you can do ok? Your feet will get better ok?
150	Patient:	Ok

Some closing sequences are different from the rest in that after the reclose implicature the interactants turn to something else which might or might not have been discussed earlier in the consultation before reverting to the normal formal closing as already discussed above. For example Extract 08 above reveals the presence of an insertion and side sequences within the closing sequence as discussed in section 3.3.11. From line 104-112, Doctor C and his patient discuss the end of the payout of the disability grant which seems to be the only source of income for this patient. The doctor suggests that the patient would have to come up with a plan on how to earn a living (*line 113*). He asks the patient if she would get a job (*line 115*). Then in an insertion sequence he enquires "What work did you do before? Where did you work before?" (*line 123*) The topic of this question is different from the 'sick pay' they were discussing in lines 104-112 but the subject is the same namely, the doctor's interest in the patient's livelihood. Then, the doctor introduces a new topic in the form of the advice that he gives the patient with regard to disclosing her HIV-status, "*And you don't need to feel like you have to tell people about the HIV*" (*line 139*). This is a very important issue that HIV-positive people have to deal with in their daily lives. Furthermore, the

introduction of the nursing sister in lines 76 and 144 may seem that there are three parties involved in the interaction but the nursing sister is in the adjoining room and apparently only contributes to the consultation when the doctor verbally invites her to. From the ease with which she is integrated into the conversation it is evident that she can overhear parts of the conversation between doctor and patient if she is not busy with other patients. But because the doctor-patient interaction is confidential, even she is not present in the consultation room except when expressly called in to perform her duty as a clinic staff.

Also, the reclose sequence in Consultation 14 is an illustration of this type of interactional practice. When Doctor C says, "*great, nice to see you…"* (*line 281*), the patient's response in (*line 282*) and the subsequent turns that go up to line 285*, "For next month you can only see Sister hey?"* signal the end of the consultation and indicate that the official business of the consultation is over. However, the doctor initiates a topic change to pleasantries about a more personal and casual issue: the denomination to which the patient belongs, *"Which church are you going to?"* (*line 287*) re-engages the patient in the interaction. From this stage of the interaction even the tone and mood of the consultation changes from being serious to becoming more personal and light hearted as seen from the chuckles and the doctor's, "*Ok man…*" (*line 289*). But this time around, the patient too realises there is nothing left to do and offers his thanks and adieux with "*Thank you doctor, bye"* (*line 290*). This type of closure occurs frequently in other kinds of conversation, thus the HIV/AIDS consultations using ELF follow established patterns

The sequential organisation of some of the consultations in the present study is influenced by the turns that develop into these sequences especially because sometimes the participants, patients in particular, do not respect conversational rules such as not providing relevant answers to questions or avoiding them completely for various reasons. Some of these reasons include the fact that medical consultations may follow different rules to regular conversations particularly due to the power asymmetry and that the HIV-consultation may have its own conventions. Furthermore, the person who does not follow the rules (usually the patient) may be unfamiliar with or intimidated by the context and the fact that the English proficiency of the participants do not quite match and thus could possibly be an ELF feature of the HIV-consultation. For example Consultation 11 provides an example of a consultation between a doctor and a patient that has prolonged sequences because the doctor was not getting the right answers to her questions. Comparatively, the doctor's turns are more elaborate than those of the patient. In this case, because the patient's responses are not relevant to the questions asked or clear of ambiguity, from line 84 forward, the interactants each take more turns for explaining and confirmation checks, making the sequence more drawn out.

Considering the fact that the HIV/AIDS consultations involve people interactionally engaged in a social activity, this flouting of conversational rules (often referred to as conversational maxims) is inevitable. This is an aspect that is investigated in the field of pragmatics. According to Grice (1975: 45) in the co-operative principle, interactants should aim to make their conversational contribution, "such as is required, at the stage at which it occurs, by the accepted purpose or direction".

In the same way, when Doctor B poses the question, "*Are you feeling well*?" (*line 79, Consultation 7*), the next turn is expected to be the patient's response to this question. But as evident in the extract, the patient flouts two of the four maxims of the co-operative principle: the maxim of relation, which requires that interactants should make their contribution relevant to the interaction and the maxim of manner, which requires interactants to be clear in what they say, avoiding any ambiguity or obscurity. These maxims are flouted because the patient's response is not an answer to the question the doctor asked. He does not say if he is well even though the fact that he is well can be inferred from the introduction of *'but'*. In this case, he has deliberately left out the first part of his answer which should have been, '*yes, I am well…*' before introducing the *'but'*. Instead he employs the ELF communicative strategy of topic fronting and goes straight to what is more pressing and troubling to him, "*But I'm just developing some spots"* (*line 80*), even though he is not by any means specific or clear about these spots. This can be seen as his way of prioritising his information through topicalisation (Meierkord 2006b). This is a discourse strategy used by ELF users to move focussed information to the front of an utterance, signalling to the hearer what needs attention. This shows agency on the part of the patient which is not unexpected in medical consultation: P is seeing a doctor, has the chance to raise concerns, and actually does so.

5.2.3 Repair and the resolution of misunderstanding

Understanding in conversation is a jointly constructed interactive process, which is dynamic and co-operative and one in which all participants in the conversation continuously engage (Vasseur, Broeder & Roberts 1996: 17). The interactants are therefore seen to work together in constructing mutual understanding and sharing the conversational responsibility of arriving at a sufficient degree of understanding. Mutual understanding might not always be achieved, as has been pointed out in some research (see e.g. Linell 1995). While this can be true of any type of interaction it is more likely to be so in ELF interactions. Much research has been done to show that, by nature, ELF communication is collaborative and co-operative (e.g. Firth 1996; Seidlhofer 2001; Meierkord 2002; Mauranen 2006). Consequently, misunderstanding or "non-understanding" (see Pitzl 2005:

52) as it is sometimes called still occurs as this process of mutual construction of understanding is very often partial and fragmentary (Linell 1995: 184). Understanding and misunderstanding are extreme points of a continuum along which varying degrees of both can be achieved (Bremer 1996; Pitzl 2005). Bearing this in mind, I take inspiration from the conceptualisation of misunderstanding described as a point in a conversation "when the listener realises that s/he cannot make sense of (part of) an utterance" (Pitzl 2005: 52). This can in no way be absolute because not making sense of an utterance can be attributed to many reasons. In addition to this I am inspired by Mauranen (2006: 131)'s more comprehensive conceptualisation of misunderstanding which considers both 'prospective' and 'retrospective' behaviour. This refers to interactive behaviour whereby interlocutors pre-empt misunderstanding before they occur or where they are resolved after they occur respectively. Misunderstanding and understanding may vary from a total lack of understanding to more or less complete understanding (Allwood & Abelar 1984, cited in Pitzl 2005: 53) and situations where the participants make guesses about speaker behaviour. The doctor-patient consultations like other forms of conversation are also prone to misunderstanding of some sort. In the present study, I identify misunderstanding that becomes apparent when participants experience a breakdown in communication and signal it using communicative strategies such as confirmation checks, questions and repair. Linell (1995) indicates that the length and salience of the sequence in which misunderstanding is negotiated vary with the length of negotiation, indicating a corresponding causal gravity. Interactants may more easily trace back a misunderstanding to its causal core in a shorter sequence than they would in a longer one.

5.2.3.1 Negotiating beyond misunderstanding and "let-it-pass"

Although there is a general assumption that ELF communications are riddled with misunderstanding due to the fact that interactants come from different linguistic backgrounds and possess varying proficiencies in English, there is evidence in my data that confirms other findings that misunderstanding is not as common an occurrence in lingua franca interactions as one would expect (Firth 1990; House 2003; Mauranen 2006) and that if any do occur they are remarkably few (Bae 2002; Pitzl 2005). It is difficult to attribute the misunderstandings that do occur in my study specifically to the use of ELF since this study has not undertaken a comparison of ELF and L1-L1 interactions, and between L1 speakers there are obviously also events of misunderstanding. However, Meierkord (2006a) and Firth (1996) attribute much of the achieved level of understanding in ELF and lingua franca communication to negotiation and to what they refer to as the "let it pass principle". In negotiation, both interactants generally accept some of the phonological, phonetic, lexical and syntactic variations which may cause misunderstanding as part

of the communicative process. They are aware of the fact that they have varying and limited proficiencies. Therefore, they strive to achieve a degree of understanding and mutual intelligibility. That is, the interlocutors try to understand the message despite these limitations and deliberately ignore some of the linguistic items that they misunderstand, simply abandoning a problematic sequence and continuing the conversation by moving on to a new topic. It is possible that a speaker and hearer misunderstand one another without either of them recognising such a mismatch in the course of their conversation. Conversation analysis cannot always account for such misunderstanding that may be obvious to the outside observer or to the analyst, but not to the participants themselves. However, specifically in ELF-interaction it has been pointed out that interactants sometimes recognise misunderstanding, and either do not respond to such recognition at all, or try to resolve it and if they do not directly succeed, they "let it pass" as it is not critical to the main theme of the conversation (See Extract 10). The following sections give extracts from my data that illustrate various ways in which misunderstandings are recognised and managed in the consultations.

In Extract 10 below (taken from *Consultation 1*) for example, after Doctor A has explained the different stages of HIV disease to the patient, she notices his belt. Here we find an 'insertion sequence' (lines 38 to 61) in which the doctor interrupts her discussion of symptoms that motivate a decision to prescribe ARVs (turn in *line 37*, and again *line 62*), and introduces a new topic with her compliment, *"Ugh this is a nice belt…"* (*line 38*). Although it is not clear what the patient says in lines 39 and 41, Doctor A's question, *"Oh is it a traditional* belt?*"* (*line 40*), repeated in line 42 seems to suggest that if the belt is 'traditional' and is '*not for the looks'* it could be an indication that the patient subscribes to some form of traditional healing. In repeating the question, the doctor either seems to indicate her seriousness about knowing what the belt symbolises to the patient or she does so because she did not clearly hear what the patient said and wanted to give an appropriate response. But when the patient responds with an emphatic, *"No"* (*line 43*), he could be answering any of the two questions the doctor asked, thus, *"No, it's not traditional"* or *"No, it's not for looks"* – so, an ambiguous answer. But from the tone and urgency in his voice he could also be suggesting that the doctor discards any ideas she might have in her mind about the belt. However, this interpretation of the interaction at this point may not be correct but the doctor 'lets it pass' and does not insist on clarification.

The doctor moves on to something else: the use of the belt, and then directly suggests what it might be made of. This seems like an effort to keep the conversation going, not one where answers are

critical for the success of the consultation especially as the doctor laughs off the function of the belt, "…*Is it the jackals*" (*line 44*). A misunderstanding occurs and is clear to the outsider as the doctor cannot identify the skin of the animal from which the belt is made. The patient tries to circumscribe as he does not know the English name that the doctor will recognise. Doctor A suggests it is a jackal; but following the cues of the patient that it is a sea dog, she suggests it may be a seal – which the patient cannot confirm (*lines 44-53)*. When the patient says, *"Errh it's a what can I say, it is a it's a sea dog"* (*line 45*) it indicates he is trying to look for the right word and, *"Is a dog what can I say I don't know the name of the dog you know from the sea they have small dogs"* (*line 51*) indicates a gap in L2 English vocabulary. Apparently the belt is made from the skin of some sea animal that the patient knows as a "sea dog". In this context, this could also be a literal translation from the patient's L1. This is not an unusual occurrence in ELF, and this excerpt illustrates how the participants jointly try to construct a meaning that will satisfy both. Although the misunderstanding is not resolved both interactants eventually give up the search for the animal's name and agree on the fact that it is a "water animal" (*lines 56-58*) and there is resolution. This again is an insertion sequence as they apparently decided that it was futile trying to decide on the use of the belt or what animal it was made from. The doctor eventually abandons the troublesome item in the sequence and instead changes the topic to a more relevant and important issue when they return to the main theme, namely why it is important for the patient to go onto ARVs. So in line 60, she turns attention back to the patient's health and wants to know first if the patient has any pain and then when s/he would be ready to start on ARV treatment. This excerpt illustrates the co-operative nature of ELF interactions that has been recognised and extensively discussed in previous lingua franca research (e.g. Firth 1996; Seidlhofer 2001; Meierkord 2002).

Extract 10: Joint negotiation of meaning to resolve misunderstanding

37	Doctor A:	Eh! We have HIV disease we have stage 1 no symptoms, stage 2 little bit of symptoms, stage 3 is when somebody has that white thing on the errh realm of the tongue if you look in the mirror you will see it. Just just you know I will just like to explain to you that if we if we start ARV it is not for nothing ok? S can you get up (Background noise)
38	Doctor A:	Ugh this is a nice belt, did you buy it?
39	Patient:	((unclear))
40	Doctor A:	Oh is it a traditional belt?
41	Patient:	((unclear))
42	Doctor A:	Is it traditional? It's not for the looks?

43	Patient:	No
44	Doctor A:	Oh (laughs) what is it for? Is it the jackals
45	Patient:	Errh it's a what can I say, it is a it's a sea dog
46	Doctor A:	Eh?
47	Patient:	It is a sea dog
48	Doctor A:	Is it a seal?
49	Patient:	It's a dog that we get from the sea
50	Doctor A:	A dog from the sea. Is it a seal?
51	Patient:	Is a dog what can I say I don't know the name of the dog you know from the sea they have small dogs
52	Doctor A:	Jackals
53	Patient:	From the sea, we get from the sea
54	Doctor A:	Only at the beach
55	Patient:	At the beach
56	Doctor A:	But it's not a water animal
57	Patient:	It's a water animal
58	Doctor A:	It's a water animal ehm?
59	Patient:	Yeah
60	Doctor A:	Any pain?
61	Patient:	Nothing
62	Doctor A:	Ok alright ((ruffle of paper)), alright if you were to start on ARVs when would you like to start?
63	Patient:	Uhmm, uhmm!

Previous research has noted that the analyst is faced with the difficulty of stating with a fair degree of certainty what a speaker really meant in a particular utterance or what the communicative effect of the utterance was to the listener (see McGregor 1985: 3). Thus one cannot be absolutely sure why the interactants stopped trying to resolve the lack of clarity about the kind of skin that the patient's belt was made of in the above extract. As it was not a critical element of the overall goal of the consultation, they managed to go around it and could continue the consultation with little loss in terms of achieving the primary communicative aim. There were attempts at "repair" (see section 5.2.3) which were abandoned when a limited degree of agreement had been reached, and the main theme was resumed.

CA distinguishes four kinds of repair, namely (i) self-initiated self-repair, (ii) self-initiated other-repair, (iii) other-initiated self-repair, and (iv) other-initiated other-repair (Liddicoat 2007: 173). In the analyses that follow, I shall distinguish between repairs from two perspectives: first I shall attend to repairs that are doctor-initiated (thus ones that are either self-initiated and self-repaired by the doctor, or other-repaired by the patient), and second I shall attend to repairs that are initiated by the patient (thus ones that are either self-initiated and self-repaired by the patient or other-repaired by the doctor).

5.2.3.2 Doctor-initiated repair

A trouble spot in Extract 11 below (*Consultation 12*) that necessitates but illustrates doctor-initiated self-repair can be seen in line 83. The doctor changes topic from the blood pressure medication to an assessment of the patient's condition. The doctor suggests further blood tests and tells the patient of her suspicion of a condition which she describes using an abbreviation that is evidently unknown to the patient, "*...Just uhm the other thing that I could do, I suspect that that is PPE ok?"* (*line 83*). She immediately realises that the patient might not know what PPE is and that this may unduly alarm him. This is what Mauranen (2006: 137) has described as "proactive repair" because the speaker pre-empts a misunderstanding and immediately initiates the effort to subvert it. So she proactively initiates self-repair in the same turn to explain what the abbreviation is, *"...That's something that is associated with HIV alright?"* (*line 83*), and further tries to allay the patient's fears by reassuring him, *"Uhmm. I really don't think it is anything more worrying than that…."* (*line 85*) and promises the intervention of a skin specialist (*line 86*). The repair effort is successful as evident in the patient's satisfaction and total agreement with the doctor's plan, *"Yes exactly"* (*line 86*). Although the patient's agrees, "Yes exactly" (*line 86*), the doctor's explanation has only helped to give him a peace of mind, because it does not really say what PPE is. But this extract also illustrates how interactants collaborate in joint negotiation of meaning.

Extract 11: Doctor-initiated-self repair

83	Doctor A:	Errhm then we can do the uhm bloods next month hey?'Cos you are almost a year on treatment hey? Just uhm the other thing that I could do, I suspect that that is PPE ok? That's something that is associated with HIV alright?
84	Patient:	Yes
85	Doctor A:	Uhmm I really don't think it is anything more worrying than that. But to be on the safe side we can make an appointment with a skin

specialist and they just take a small, small, they take one lesion. They take it out, they send it away to the lab, they have a look under the microscope and tell you exactly what it is. Would you like that?

86 Patient: Yes exactly

Also in Extract 12 below (from *Consultation 12*), the doctor establishes that the patient does have a wife. The doctor initiates a topic change and asks the patient, '*Kids, have you got kids?* (*line 55).* In the lines that follow (*lines 55-67*) the consultation focuses on the children in a question-answer interchange between the doctor and patient, in which the patient reveals that he has two children: one, a seven- year-old and the other of about ten months. Doctor B is concerned about the children's HIV-status as is evident in her line of questioning as she wants to know whether both children have been tested for HIV (*line 61*). The patient's response reveals that only one of the children has been tested while the other one has not yet been tested because he is back home (*line 62*) (the name of the place is not mentioned because the anonymity of the participants is maintained). This response introduces a trouble spot in the consultation since it is not clear from what the patient says which one of the children has been tested – the older or the younger child. This limited information provided creates confusion and triggers doctor's request for clarity in a repair which she initiates in the following question, "*Which one is back home*?" (*line 63*). The doubt is cleared in the subsequent repair sequence given in response by the patient, "*The seven-year-old"* (*line 64*). At this point the confusion is cleared. However, the simultaneous speech between the interactants in lines 63 and 64 can be seen as an indication that both doctor and patient are jointly and contingently contributing to the outcome of the interaction. By inferring from the social and economic background of the patient the doctor seems to have decided that it is most likely the older child that has not been tested (*line 63*). This is confirmed in the patient's next turn in, *"the seven-year-old"* (*line 64*) which is echoing Doctor B's previous turn. This resolves the misunderstanding mentioned above. This type of repair is similar to the 'interactive' repair discussed in Mauranen (2006: 137). But, the doctor mistakes the sex of the child when she proceeds in her next turn to advise the patient, "*You must test her as well eh?"* (*line 65*), a piece of advice with which the patient agrees (*line 66*) but for some reason he does not bother to correct the doctor's error. This could also be considered as a form of L1 interference.

Extract 12: Doctor-initiated patient repair

35 Doctor B: Girl friend, Wife? Have you got a girlfriend or a wife?

36 Patient: Wife

37 Doctor B: A wife. Where is she?

38 Patient: At home
39 Doctor B: In ((name of country))?
40 Patient: Here in South Africa
41 Doctor B: Oh ok where? Where?
42 Patient: ((name of location)). We stay together
43 Doctor B: In ((name of location))
44 Patient: Yeah
45 Doctor B: Is she also tested?
46 Patient: Yes
47 Doctor B Is she positive as well?
48 Patient: Sure
49 Doctor B: What is her CD4 count?
50 Patient: Ah it's still alright
51 Doctor B: It's still high. Aah ok so you understand that
52 Patient: Yeah
53 Doctor B: You still have to keep checking after every six months
54 Patient: Yeah
55 Doctor B: Kids, have you got kids?
56 Patient: Yeah
57 Doctor B: How many?
58 Patient: Two
59 Doctor B: Two kids. How old are they?
60 Patient: Seven years and errh nine months almost turning ten
61 Doctor B: Have you tested both of them? Are they fine?
62 Patient: Only one. The other one I've not because he is back home
63 Doctor B: Which one is back home? [The seven years]
64 Patient: [The seven-year-old]
65 Doctor B: You must test her as well eh?
66 Patient: Yes

5.2.3.3 Patient-initiated repair

Patient-initiated repair does occur during HIV/AIDS consultations, albeit sparingly.

Then Extract 13 (*Consultation 12*) illustrates doctor-initiated patient repair, in this extract, the doctor raises three different issues. She firmly suggests that the child must be tested, ascertains the

patient's readiness to start the ARV medication and in the same sequence emphasises the necessity for the use of condoms in, "*She must be tested. Ok so you're ready neh? You are using condoms at home*?" (*line 67*). But when the patient responds with, "*Sure*" (*line 68*) it triggers a repair because the doctor realises that the response could have been relevant to any of the three issues she raised but was not particular about any. But when she says, "*Very important…*" (*line 69*), the doctor realises she needs to explain to the patient what exactly she is saying is very important. Consequently, she again proactively self-repairs in the later segment of line 69 when she elaborates on the short and long term implications of using condoms on the patient's health by clarifying, "*So if you don't use a condom she is gonna continue re-infecting you"*. The repair is successful because the doctor's elaboration ends with a confidence-boosting comment, *"...I can see you are very vigilant"* This apparently surprises the patient and builds his confidence as evident in the question that follows requesting some sort of confirmation of the doctor's belief in him, *"Is it?"* (*line 70*).

Extract 13: Patient-initiated doctor repair

67	Doctor B:	She must be tested. Ok so you're ready neh. You are using condoms at home?
68	Patient:	Sure
69	Doctor B:	Very important. It's even more important now when you are on treatment because we're gonna reduce your viral load, even though your wife's CD4 count is high your viral load is gonna be lower than hers because yours is gonna be controlled on treatment. So if you don't use a condom she is gonna continue reinfecting you. Six months comes we gonna repeat your viral load and it's gonna be high and we'er gonna tell you, you are not been drinking your tablets and we're gonna fight with that because I can see you are very vigilant.
70	Patient:	Ooh Is it?

The exchange in Extract 14 (*Consultation 3*) also illustrates patient-initiated doctor -repair. It comes after the doctor has just physically examined the patient on the bed to make sure there are no other problems. But as she prescribes the aqueous cream she says, "*So I am stopping these…*" and goes on explaining how the cream is to be applied (*line 70*). Although the patient responds, *"Sure"* (*line 71*) it becomes evident later in the conversation that he is not quite sure about what exactly the doctor meant to stop in line 70. Even at this point it is not yet clear to the patient that the doctor was talking about stopping the high blood pressure tablets because after the doctor returns to continue

the conversation from the sequence where she suggested the discontinuation (*line 80*), the patient's confusion is evident in the overt request for clarification, "*Sorry*?" (*line 81).* At this point the doctor realises the problem and self-repairs by repeating her decision in the utterance, "*We're going to discontinue the high blood tablets*" (*line 82*). The doctor establishes resolution at this point. She does this by elaborating, "*discontinue the blood pressure tablets*" and by repeating with a less sophisticated term "*stop*" – as equivalent of 'discontinue'.

Extract 14: patient- initiated doctor-repair

67	Doctor A:	((Screeching of bed)) No other problems eh? OK right ( )
68	Patient:	yes
69	Doctor A:	Ok alright, I'm going to give you something for that ((screeching on the floor and ruffle of paper)). Ok today i::s the 18th so I'm stopping these and I'm just adding a cream and I suggest you just, here you go, you can apply some of that twice a day
70	Patient:	Sure
71	Doctor A:	To try and prevent you from scratching alright? I'm gonna give you some aqueous cream just to use it as soap alright, instead of using the soap to prevent the skin from being dry. You can also use a vegetable oil actually
72	Patient:	Vegetable oil?
73	Doctor A:	Y:e:s it's also good for the skin
74	Patient:	Sure
75	Doctor A:	But I'm gonna give you the aqueous cream alright? Have you had these before?
76	Patient:	Yes
77	Doctor A:	They look different now hey?
78	Patient:	Yes the first time I got these was last month
79	Doctor A:	Yes, ok we're going to discontinue these
80	Patient:	Sorry?
81	Doctor A:	We're going to discontinue the high blood pressure tablets. I'll stop them
82	Patient:	Sure
83	Doctor A:	Errhm then we can do the uhm bloods next month hey?'Cos you are almost a year on treatment hey? Just uhm the other thing that I could do, I suspect that that is PPE ok? That's something that is associated with HIV alright?

84	Patient:	Yes
85	Doctor A:	Uhmm I really don't think it is anything more worrying than that. But to be on the safe side we can make an appointment with a skin specialist and they just take a small, small, they take one lesion. They take it out, they send it away to the lab, they have a look under the microscope and tell you exactly what it is. Would you like that?
86	Patient:	Yes exactly

Furthermore, in Extract 15 (*taken from Consultation 1),* Doctor A apparently had asked the patient previously to tell his spouse about his HIV-positive status. But her question in *line 7* indicates that she realises the patient's reluctance to do so as revealed in his negative response, "*A:ah about the status"* (*line 8).* Doctor A changes the topic in line 9 abandoning the desire to know what the patient told his wife and went straight to the more serious matter of getting the patient on ARVs (*line 10*). But she wants to know what the patient thinks about this. The patient's response in line 12 is punctuated with interjections such as '*wow'* and '*eish*' indicating his fear of being on ARVs for life and the fact that he finds it quite overwhelming. Linguistically, the use of the interjections could be interpreted as an indication of hesitation to face the situation and the fact that he might find explaining his view about ARVs in ELF quite challenging. Doctor A affirms his fear with the question, *"Are you worried about …"* (*line 13*) and *"The lots of tablets because it's gonna to be five tablets a day eh?*" (*line 15*), a fear which the patient reiterates by saying that his worry is the fact that the treatment is for the "*whole life y'see?"* (*line 16*). Doctor A cuts in to say ARVs are a "lifeline" that has been given to the patient. The patient realises that the doctor has misunderstood him because he was talking of the fear of being on treatment for the rest of his life. So he initiates a self-repair which clears the misunderstanding. His explanation, "*That is why I'm not feeling so good but it's nothing it's part of life I can carry*" (line 18), indicates that his problem was not a lack of understanding of the fact that ARVs are a lifeline but rather with the fact that he has to be on them for the rest of his life. The doctor catches on the cue and acknowledges his worry by restating and verbalising this fear, "*Ok so you have this fear about going on this treatment fi::ve tablets a day for the re::st of your life eh?*'(*line 19*). But when the patient says, "*I can't do it*" (*line 20*) the doctor understands the he wants it but is afraid. So her reply, "*But on the other hand you want to*" (line 21 makes it clear that they are both talking about his worry as well as his desire to start his treatment. This, the patient confirms with a "*Yes*" (*line 22*) which indicates a successful resolution. This is why the doctor replies with '*Ok*' and then changes the topic and requests to physically examine the patient.

Extract 15: Patient self-repair

7	Doctor A:	So you did speak to her about HIV but you didn't tell her about your status?
8	Patient:	A:ah about the status
9	Doctor A:	Ok alright ok oh how do you feel about ARVs because I see P has been giving you counselling about ARVs:::? A:n:d she spoke to you about having to start ARVs?
10	Patient:	Y:e:s, yes
11	Doctor A:	What is your feeling about it?
12	Patient:	I:: just because I:: wow I:: eish you never stop errh to to to to of drinking the ARVs. I refuse of it b'cos I can't eat errh carry on I can't eat errh so much errh a lot of errh of of tablets 'cos sometimes errh I can't say agh errh I can't eat it I can't drink it but I will try that is why I feel so bad
13	Doctor A:	Are you worried about …
14	Patient:	Ye::ah and…
15	Doctor A:	The lots of tablets because it's gonna to be five tablets a day eh?
16	Patient:	then I was going to take it a long may be the whole life y'see
17	Doctor A:	Y:e:s, yes it's a lifeline
18	Patient:	That is why I'm not feeling so good but it's nothing it's part of life I can carry
19	Doctor A:	Ok so you have this fear about going on this treatment fi::ve tablets a day for the re::st of your life eh?
20	Patient:	I can do it
21	Doctor A:	But on the other hand you want to
22	Patient:	Yes
23	Doctor A:	Ok S just quickly come over here, would you like to sit on the be::d and let me quickly have a look at you? Can I can I quickly just have a look at you?
24	Patient:	Yes

5.2.3.4 Summary

In the sections above I have described linguistic features that are of primary interest in CA analyses of conversations, and have identified them as they are reflected in the data collected in HIV/AIDS consultations. Specifically, attention went to turn-taking in conversation, sequential organisation and various forms of repair. Where ELF features identified by key researchers in the field of ELF became obvious in the analysis, these were specifically pointed out. Particularly, attention went to the ways in which interactants in lingua franca situations collaborate and co-operate in their effort to achieve mutual understanding and resolve misunderstanding. They sometimes resort to literal translation or appropriate words from their L1 to explain things in ELF because their vocabulary is limited. This is intended to facilitate communication even though the data shows that this is not always achieved. Overall the analyses presented in section 5.2 confirm some findings in earlier research that indicate that the participants in lingua franca communication often get by in relying on the 'let it pass principle' and tend to not to be critical of each other on less important communicative goals, but strive for mutual understanding on the primary goal of the consultation.

Some misunderstanding and repair result from language use that is characteristic of ELF usage, particularly evident in the use of words. This type of usage of lexical terms that is not consistent with presumed NL-usage can cause misunderstanding although evidence from the data shows that the interactants are aware of these lexical complexities and deal with them using various strategies which are discussed later such as rephrasing, request for explanation and detailed explanation (sections 5.3.1.1), repetition and demonstration (sections 5.4.1 & 5.4.2). This is consistent with earlier findings of research in lingua franca communication and misunderstanding (House 2003, Mauranen 2006) that indicate that the participants generally negotiate meaning and often operate on the 'let it pass principle' This variation is an indication that aspects of language use such as context, culture and interactants' linguistic background impact on language.

5.3 DA perspective on discursive features in HIV/AIDS consultations

The interactants sometimes display their understanding and give their explanations of the medical terminology and concepts through the use of linguistic strategies such as repetition, verbal and detailed explanation coupled with demonstrations, analogies, metaphors, and occasionally code-switch to their L1. Considering the fact that all the participants in the study possess varying proficiencies in ELF and that the patients are less knowledgeable in health matters than the doctors, it is obvious that most of them struggled with understanding some of the medical terminology and

HIV-related concepts, as well as in mastering the instructions and names of the different medications they were given. This explains why there is evidence across the data corpus of the enormous effort the doctors put into explaining these terms and making sure the patients understand them to ensure positive medical outcomes such as adherence and return to health. The elaborate explanations given are indicative of the fact that the doctors are aware of the fact that the consultation is delicate in that any mistakes resulting from lack of understanding could have serious consequences for the patient. This indicates a high level of familiarity with the situation by especially the doctors as well as the impact of the context on the nature of ELF in this context.

5.3.1 The description of the medication and HIV/AIDS-related concepts

This section discusses some of the linguistic strategies that the interactants use to describe both the medication and HIV/AIDS related concepts. It also highlights the fact that differences in the socio-cultural and linguistic background of the interactants impact on the manner in which people talk.

5.3.1.1 Detailed explanation of the medication

Bearing in mind the multicultural and diverse linguistic backgrounds of the participants, it is obvious during some of the consultations that the lexical items and expressions used to describe the HIV disease and the medication reveal a peculiarity of the field of medicine and show that the English spoken in this context has been indigenised as has been reported in previous studies (see Meierkord 2002, 2004). In this section I begin by highlighting the lexical items that relate to the HIV/AIDS medication, then I discuss the manner in which the participants talk about HIV/AIDS and related concepts focusing on the lexical and discourse features of HIV/AIDS consultation that reflect the socio-cultural and institutional context of ELF in the clinics highlighting indigenisation as one of the major characteristics of lingua franca communication (Mesthrie 2002). This would indicate situations in which certain English lexical items have been cleverly modified with sounds or prefixes and suffixes from the indigenous languages to convey particular meanings (Kachru 1990, 1997).

In the present study, there is ample evidence of doctors and patients using simple every day speech and registers to describe symptoms, complaints and even the medication despite the technical nature of some of the concepts that are discussed during the HIV/AIDS consultation (Wetherell et al. 2002; Traynor 2006). This puts a lot of pressure on the doctor whose duty it is to make sure the patients know the different types of medication that are given to them and their dosage instructions.

Consequently, doctors reveal a lot of sensitivity to patient's level of understanding and go to great lengths to explain each one of the medication as best they can in a language that is simple enough for the patient to understand even if it means incorporating local imagery and colloquialisms. The constant use of the names of the different medication is to emphasise that they are technical but it is to draw patients' attention to the physical appearance and function of each medication. This is why linguistic strategies such as detail explanation, demonstration and analogy are used. This helps the patient to avoid any possible confusion of the medication as any such confusion could have devastating consequences that could make an already complex medical condition more complicated. The HIV/AIDS consultations in this study are characterised by the use of very technical terminology and concepts that are unique to this field of medicine. The following are randomly picked ARVs and other medications that are frequently named during the consultations by the different doctors who did the consultations. There is the constant reference to medication such as ARVs and specifically most of the adult regimens such as '3TC', 'D4t', 'Nevirapine', 'Stoicrin', 'Lamivudine,' 'Efavirens', 'Virate', 'Bactrim' and vitamin supplements such as Vitamin BCo. The issue here is that the communication is taking place between the patients who are less knowledgeable in medical terminology of the names of the medications that are prescribed to them and the doctors who are the experts and display a high level of familiarity not only with these terms but with their meanings, functions and even chemical composition.

One of the most common and recurrent communicative strategies present in the prescription and instruction sequences used by doctors during ELF HIV/AIDS consultations to enhance understanding and transfer of vital information is the use of detailed explanation and demonstration. This strategy is used by all the doctors in the present study. Extract 16 below (taken from *Consultation 8*), for example, illustrates how much effort Doctor C puts into making sure that the patient knows his medication and understands how to take it. From the ongoing dialogue, it is evident that some of the drugs have changed in quantity and shape and it is absolutely important for the doctor to methodically draw the patient's attention to this change. So he pours the tablets out onto the table (*indicated by the crackling of tablets, line 81*) and verbally explains the change that is physically obvious to the patient since he is looking at the medication as the doctor explains, "…*The Nevirapine is staying the same*". When the patient responds in the affirmative in line 82, the doctor then moves to the next medication to explain what has changed, by verbally evoking the visual component of the interaction by inviting him to look, *"You can see that although it looks like that, (this is the purple ones), it's going to look like this in the future, okay?"* (*line 85*). He goes on to describe even the shape of one of the drugs simultaneously giving the verbal explanation with physical demonstration of the appearance and name of the drug, which he emphasises through

repetition, "*It's that one. You will see that it's Lamivudine, Lamivudine"* (*line 89).* This strategy seems to pay off as the patient also repeats the name of the drug and confirms his understanding of the explanation with a "*Yeah*" (*line 90*).

Extract 16: Detailed explanation and demonstration

73	Doctor C:	They have reduced her, they have reduced her
74	Patient:	from 40
75	Doctor C:	To 20 ok. We just need to go through your tablets to make sure it's better there (guess) okay?
76	Patient:	Ok
77	Doctor C:	((ruffle of paper))
78	Patient:	It's from Friday to
79	Doctor C:	Ah two weeks. I'll put it in the book. Ok errhm P*** let's just see *** do you have your tablets with you?
80	Patient:	Yes I do
81	Doctor C:	Then we'll just have a look and see what we can change ((crackle of tablets)). Ok so this one let's see this one is staying the same ok? The Nevirapine is staying the same.
82	Patient:	Yes
83	Doctor C:	This one is Lamivudine and this is changing but it's the same one. But you can see we can open it. I'm going to open
84	Patient:	Hmm
85	Doctor C:	You can see that although it looks like that, ((this is the purple one)). It's going to look like this in the future, okay?
86	Patient:	Ok alright
87	Doctor C:	Okay? That one is that one; it's not the triangle any more
88	Patient:	Hmm
89	Doctor C:	It's that one. You will see that it's Lamivudine, Lamivudine
90	Patient:	Lamivudine yeah

The use of detailed explanation is evident when doctors discuss the issue of time and how this impacts on the treatment. The time for taking the medication is a very important factor in the treatment of HIV/AIDS. This is constantly emphasised in the consultations by the doctors, which reveals the difference in the participants' levels of familiarity with the medication and the way they function. It is very evident from the consultation that the time at which a patient decides to be

taking his or her medication is of utmost importance. The doctors know that the patient responds more positively to the treatment if s/he approximates and takes the medication at the same time each day, morning and evening in cases of multiple doses. This implies that the patient has to take his/her medication wherever they go: to work or when they travel, in order to avoid taking them at different times. This is a problem to some of the patients who are not ready to disclose their HIV status to other people. So the issue of time becomes a personalised thing where each patient has 'his/her' time. In Consultation 7, the doctor tries to explain the need for time consciousness and the effect this has on the patient's treatment outcome and social life. In fact expressions such as Doctor B's, "*So what time have you chosen now for yourself?"* (*line 17*), the patient's, "*Myself, I've chosen to take them by:: five o'clock"* (*line 18*), *and Doctor B's, "Neh, 'cos WE don't choose your time. We want you to choose your time that you will be able to adhere to, to, to you know to"* (*line 41*) are frequent within the consultations. The doctor explains why this is medically important, *"I just want to make you aware that even when you are not going to work you're still gonna wake up at the usual time so that you can drink your medication on time otherwise it's not gonna work"* (*line 39*).

5.3.1.2 Use of metaphor and analogy for HIV/AIDS and related concepts

During and across all the consultations by all doctors in the present study, there is as expected the use of medical jargon and vocabulary by doctors to describe illness. The problem with such language use as pointed out by some researchers is that this can result in a lack of comprehension because of the fact that the interactants do not belong to the same jargon in-group (Todd & Fisher 1993: 18). They observe that since the jargons do not have to be completely avoided in the medical context, both doctors and patients develop what linguists call receptive competence. That is, even if participants do not use a particular jargon that they encounter in their practice they must try to understand it. For example in HIV/AIDS consultations, medical jargon such as HIV virus, HIV-status, concepts such as CD4 count and viral load and safe sex are constantly used by all the doctors. But despite the recurrence of these concepts throughout the consultations it is evident that because like the medication discussed above the terminology is specialised and technical, many patients struggle to understand these concepts even though some of the doctors try very hard to explain them. Here, I present some extracts that reveal this difficulty and how interactants linguistically manage to communicate the vital information.

The viral load and CD4 count are two of the HIV/AIDS-related concepts that are constantly mentioned during the consultations in the present study. Viral load is defined in The American Heritage Dictionary of English Language (2009) as a measure of the number of virus particles

present in the bloodstream, expressed as copies per millilitre of blood. This measurement helps in treatment decisions and to monitor the efficacy of a treatment. In the case of HIV, the intention is to keep the patients' viral loads beyond detectable levels. Evidence from my data indicates that the concept of 'viral load' is not as straight forward and easy to understand as that of the 'CD4 count'. The CD4 or T-cells as they are sometimes called are one of different types of specialised cells that help protect the body from infection (Cichocki 2007). The onus then is on the doctors to make sure that the patient does understand the difference and importance of the two concepts. In Extract 17 (taken from *Consultation 16*), Doctor C tries to explain the viral load in terms of the number of the patient's CD4 count (to be discussed later) which has dropped from 555 to 470. The point here is the fact that when a patient is put on ARVs, the intention is to slow down the rate of HIV cell multiplication and possibly kill and reduce the viruses to undetectable levels. So if the viral load is high this is bad but if it is low, then that is good news. This is the rationale behind the explanation of the whole process of how to read the viral load (*lines 63-67*). Therefore a disparity in figures in itself tells the story of how well the patient is responding to treatment or not. If the previous results did not indicate the presence of any viruses but the present one does (*line 69*), it implies that something must be responsible for the results of this new test. It could be a lack of adherence, which could result in the development of a resistant strain of the virus. This is a possibility which the doctor wishes to dismiss by asking for assurance that the patient has indeed been taking the drugs, *"Yes, but we need to be careful. You do take your medicine everyday hey; you never miss it"* (*line 71*). If more viruses continue to be detected then it is a bad sign and an indication that the illness is getting worse. This is what both interactants want to avoid.

However, looking at the extract from a linguistic perspective it is very interesting how Doctor C explains these concepts and medical facts to the patient using the analogy of capturing reality in photography. "*Taking the photos of the blood"* (*line 63*) is a way to explain in lay terms the placing and examining the blood under a microscope in order to see its content with the naked eye like a photo. This helps the patient understand the process better which explains why the patient's response "*It's down now"* (*line 58*) may signal both acknowledgement and disappointment at the fact that the CD4 has actually dropped. But this could also be interpreted as a statement eliciting some clarification as to why there is the drop. This may be why Doctor C follows up with an explanation, "*Yeah but not too much. It goes up and down and things like that. So that's what*" (*line 59*), and the reassurance that this is actually normal as it happens even to HIV-negative people "*Your CD4 goes a bit up and down. In normal people without HIV it also happens like that"* (*line 61*).

The doctor insists on a test "...to check the viral load ok" (*line 26*) and uses the patient's knowledge about the concept as a basis for the explanation she gives to help the patient have a better understanding of this concept as evident in the question, "*What have you heard about it? You can explain it in Xhosa*" (*line 28*). Interestingly the patient names the concept by modifying the English expression 'viral load' into a Xhosa version 'iviral load'. This is a kind of 'lexical borrowing' whereby a word from one language is assigned to a noun class in another language and given an appropriate class prefix (Gxilishe 1992: 100). Although this might not b considered a characteristic feature of lingua franca use, it is a feature that does occur when languages come into contact and rub off on each other, in this case English and Xhosa. When the patient repeats 'iviral load' (*line 29*) she does this as a confirmation check (Mauranen 2006) to ascertain herself that she has understood what the doctor had asked. Although the patient's response, "*When you drink your tablets unregular (guess) the the viral load is down, is up"* (*line 31*) is not so apt which is indicative of her level of familiarity with the terminology, the doctor congratulates her and further explains that the viral load indicates the amount of viruses in the blood (*line 32*). It has to be checked regularly to determine the success of the ARV treatment.

Extract 17: Explaining viral load

57	Doctor C:	So your CD4 count is 467 ok?
58	Patient:	It's down now
59	Doctor C:	Yeah but not too much. It goes up and down and things like that. So that's what
60	Patient:	It happens like going down
61	Doctor C:	Your CD4 goes a bit up and down. In normal people without HIV it also happens like that
62	Patient:	Ok
63	Doctor C:	Errh the liver is fine (I just have to put that here): liver is working fine. I want to discuss this with you. This is your viral load; this is the one that tells you if there are viruses in the blood. I want to tell it, when we take blood from you we take the blood to a lab to a lab. At the lab they take photos of the blood
64	Patient:	Uhumm
65	Doctor C:	And you look at the photo then we see in this drop of blood the number of CD4
66	Patient:	Ok
67	Doctor C:	And then we also look in it to see if there are any viruses in it

		and if we see viruses in it then we report it. Now previously what we reported we didn't report any viruses in your blood
68	Patient:	Ok
69	Doctor C:	But this time we did see 27 viruses not a lot only a [few].
70	Patient:	[few] Ok
71	Doctor C:	Yes but we need to be careful. You do take your medicine everyday hey, you never miss it
72	Patient:	No I took it
73	Doctor C:	Is it?
74	Patient:	Yes
75	Doctor C:	That's great, so it was good. But just remember that that errhm we do see some viruses in your blood.

The CD4 count on the other hand is a much easier concept to explain and understand than the viral load. As mentioned above, the CD4 or T-cells, as they are sometimes called are one of different types of specialised cells that help protect the body from infection (Cichocki 2007). HIV weakens the immune system by attacking these T-cells, making them unable to protect the body from illness and infection. This implies that the higher the CD4 count the easier it would be for the body to fight infection. This explains the emphasis doctors lay on getting the CD4 levels up. From Extract 17 above, it is evident that the patient understands that it is a good sign if the CD4 count is high and that it spells danger if it drops. Thus the concern expressed by the patient in lines 58 and 60. Similarly, in Consultation 5, the patient demonstrates an understanding of the CD4 count when the doctor expresses disappointment over the low blood results and the low CD4 count which she observes, "*is 34; it's also very low"* (*line 30*). The patient's laugh (*line 31)* has a linguistic significance because even though the patient's condition is bad, the laughter is an indication that the he realises that the doctor is not aware of how grave the situation was previously. He points out "*But it's ((laughs)) it's better because the last year it was zero nine*" (*line 31*). His opinion which is later shared by the doctor is therefore that his health has actually improved with his CD4 count rising from 09 to 34 as indicated with the doctor's surprise expressed in, "*Oh it was lower than this"* (*line 32*). Similarly in Consultation 11, Doctor A indicates that she is happy with the patient's CD4 count of 271 when she declares that, "*So I'm, I'm very happy with your CD4 of 271 and I don't think you need to worry about that okay" (line 22).*

Some of the doctors find that it is much easier to explain and make the patients understand the technical concepts and certain medications by the use of local analogies and metaphors that reflect

the socio-cultural background of the patients and are well known to them. The use of these words in a South African setting is a confirmation of (Meierkord 2002: 124)'s opinion that the heterogeneity of ELF users creates "communicative hybridity" i.e. English marked by influences and incorporations of other languages and influences relevant to the participants. Hybridity does not impede understanding although it can in its most extreme form (which is not the case here), lead to a pidginised kind of English no longer intelligible to L1 speakers and therefore not helpful in ELF communication. In the present study, such metaphors and analogies not only add local colour, they are so pervasive as to be interpreted as markers of ELF-communication in the Western Cape HIV-clinics. The use of locally developed and easily accessed metaphors and analogies help the doctor and the patient to understand and communicate with each other better as they can relate to the figures of speech used in this way. This is crucial to yielding a positive medical outcome. For example in Extract 18 (taken from *Consultation 14*), the doctor discusses the CD4 count, the viral load and the ARVs and the outcome of their combined work using the metaphors of 'good people', '*skollies*' and the analogy of a "rugby/soccer team" and the 'township'. There is an indication that the patient understands what a CD4 count (*line 129*) but not the viral load is because of her question in *line 127* which comes after the doctor's announcement that her viral load is lower than detectable. This elicits an explanation from the doctor, which he introduces with "*Ok, I'm going to try to explain to you"* (*line 130*). He then verbally explains the whole process of taking a blood sample and having it analysed by microscopic means in a pathology laboratory. However, he does not use the technical terms; he simplifies the process of microscopic analysis that allows for measurement of the CD4 count and monitoring the viruses. He goes on to explain the reading of the blood sample by using the metaphor of taking aerial pictures of an inhabited space to collect information on the distribution of different kinds of people in the population, namely the 'good people' (*line 134*) as opposed to the 'bad people' locally referred to with the word *"skollies"* (*line 144*). He likens the human body to the *"township"* (a word referring to a largely informal settlement occupied by non-white South Africans) (*line 136*), the CD4 cells in the blood are likened to "people in the streets" (*lines 138* & *140*) all terms being locally known and understood.

He further explains the relationship between the other tablets and the ARV medication by using the analogy of a *"township"*. In this way he likens the destructive effect of the viruses to that of the "*skollies in the road"* who are "*killing and chasing the good people"* (*lines 144, 146,* & *148*). The response of the patient indicates that this analogy is effective as she signals her understanding with, "*Of course"* (*line 145*) and *"Ok"* (*lines 147 & 149*). The doctor explains that when the viral load is *"lower than detectable"* it *"means that the medication is killing all the viruses in the blood"* (*line 148*). The patient's excited *"Ok"* response (*line 149*) immediately alerts the doctor to the fact that

his elaboration might have given the patient the erroneous impression that the ARVs kill all the viruses in the body (*lines 150*). Such an understanding would imply that if the patient is taking her medication correctly, all the viruses in her body would eventually be killed and she would become HIV-negative again. So Doctor B follows up by emphasising in non-metaphoric terms that the medication does not cure the HIV completely but only stifles and reduces its multiplication in the blood, "*So it is important to remember that the medication is not taking the virus out of your body but it is taking the virus out of your blood*" (*line 152)* and not in the whole body because the viruses keep multiplying in some body parts. The patient however, still agrees.

Extract 18: Linguistic hybridity in the use of analogy and local metaphors

123	Patient:	Yes she told me my CD4 count is 344
124	Doctor C:	That's great and the viral load?
125	Patient:	She didn't tell me about the viral load
126	Doctor C:	The viral load is beyond detectable levels
127	Patient:	Why?
128	Doctor C:	How do you understand that? Do you understand that?
129	Patient:	That is the problem. I know my CD4 count but the viral load I don't understand about the viral load
130	Doctor C:	Ok I'm going to try to explain to you
131	Patient:	Yes please
132	Doctor C:	We take some of your blood ok,
133	Patient:	Hmm
134	Doctor C:	And then we take some of the blood and we take one drop of blood and then we put it and we take a photo of it and we in that photo we can see how many of the good CD4s are in your blood
135	Patient:	Ok
136	Doctor C:	It's like when you are taking a photo of the township?
137	Patient:	Uhmm, uhmm
138	Doctor C:	then you would see what's happening on the streets.
139	Patient:	Uhmm
140	Doctor C:	In this streets you would see all of these good people going to work
141	Patient:	Uhmm
142	Doctor C:	And they are doing fine

143	Patient:	Uhmm
144	Doctor C:	That's the CD4s. Now if everything is good in the town there Would be a lot of people going to work. But if there is a lot of skollies in the road they will start killing and chasing the good people away
145	Patient:	Of course
146	Doctor C:	now what we do is when we take the photo we see how many of the good people is there and we also see how many of the viruses are there
147	Patient:	Ok
148	Doctor C:	Now if we say it is lower than detectable it means that on this photo that we have taken we don't see any viruses
149	Patient:	Ok
150	Doctor C	So that means that the medication is killing all the viruses in your blood
151	Patient:	Is it?
152	Doctor C:	So it is important to remember that the medication is not taking the virus out of your body but it is taking the virus out of your blood
153	Patient:	Ok

Also, in (*Consultation 5*) the doctor introduces the combination of ARVs which are meant to work together, using the analogy of the joint effort of a rugby or soccer team: *"And now, this one is the combination of ARVs ok? So they are like a team, they work together. They are like a rugby or soccer team. You can't play without this one. You need to play with all of them together, ok?"* (*line 103*). These analogies would not be understood in a context in which these games are not played or enthusiastically supported. Through this strategy, the doctor makes it clear to the patient that none of the drugs is to be taken in isolation "*So that is the first rule. If one of them gets lost you must come back and get the rest of them ok? So this one you're going to take one in the morning one at night, the both of them"* (*line 105*). The metaphor used to explain the combination of pills to be used apparently lightens the patient's mood as is evident in his chuckle (*line 104*).

5.3.2 Non-English and indigenised features

Interactants in doctor-patient consultations use words and expressions that resonate with their situations and context. This tendency has been reported in reference to the use of English in Nigeria (Adegbite & Odebunmi 2006: 508). According to Levin (2006: 93) this is inevitable since disease is closely linked to the social context in which people live, especially when doctors and patients come from different backgrounds and speak different languages. This is an element of language use that is characteristic of ELF. Interactants display what has been referred to as pragmatic knowledge of their linguistic resources when they introduce linguistic elements from local languages into the English they use in that environment (Stockinger 2003: 14). Their communicative competence allows them to opt for both lexical and syntactic simplicity as it enhances their intelligibility during the consultation. As mentioned in Chapter 2 (*section 2.2.1*), some of the main characteristics of ELF are revealed in the indigenisation of the English spoken in specific cultural contexts. Code-switching, language mixing and linguistic transference are regular elements of lingua franca communication in general. These are observable in varying degrees in the ELF data of this project. These are linguistic features referred to as contact phenomena which are manifest in vocabulary, sentence structure, metaphor and colloquialisms (Kachru 1992; Meierkord 2002; Crystal 2003).

5.3.2.1 Non-standard syntactic features

There are different types of syntactic structures and patterns of conversational organisation in the doctor-patient consultations in the present study that are characteristic of ELF. Typically, when uses occur that do not fit standard rules of English, interactants seem to subscribe to the ELF principle of 'let it pass' (Firth 1996). So although the interactions comprise of utterances that range from single word sentences such as *'yes', 'no'* and *'ok'* to simple sentences of the *subject+verb+object* structure they also present evidence of very long complex sentences. It is not uncommon to find conventionally ungrammatical sentences as is seen in most information-giving/-seeking and diagnostic sequences that result from levelling and simplification (Canagarajah 2006). Similarly, the uses of non-L1 strategies such as transference have been found to be typical of ELF interactions (Meierkord 2006a). One characteristic of these ELF interactions is that the interactants are less concerned about the grammaticality of their syntactic structures and do not capitalise on the conventional grammatical mistakes of their interlocutors. This is because in ELF situations L2 varieties have different sets of often flexible grammatical rules. This flexibility gives rise to alternative linguistic forms that are typical of lingua franca use. Consequently, sentences that are conventionally considered grammatically incorrect such as the ones below are easily spotted across

the data corpus but luckily they do not disrupt the interaction and the interlocutors do not worry about them because from the ELF perspective, they are part and parcel of the language. Since these features are scattered across the data, the examples will not be presented in extracts as has been the case with the ones before. They will therefore be sorted out from the different consultations in which they occur and presented individually as follows.

Patient: *"I'm not feel like eat so much all the time"* (*line 16 of Consultation 16*) instead of 'I don't always feel like eating much', and

Doctor C: *"They did took your blood hey?"* (*line 25, Consultation 16*), to mean, 'They did take your blood, didn't they?'

Conventionally, this indicates a low level of proficiency in English on the part of the doctor. But participants use the most basic sentence structures and vocabulary items since they are both conscious of their limited proficiency in English. Their interest is therefore ploughed into achieving mutual understanding by ignoring some of the grammatical glitches. This is one of the characteristics of lingua franca communication which describes ELF talk as being overtly consensus-oriented, co-operative and mutually supportive (Firth 1996: 218). The data corpus reveals frequent occurrence of ellipsis whereby the subject in the sentence is omitted as seen in this example:

Doctor A: *"Never any discharge from the penis?"* (*line 9* of *Consultation 3*). The beginning of the question is omitted because the grammatically correct question ought to have a subject and should be, 'You never had any discharge from the penis?' There is evidence of person deixis in the form of personal pronouns such as 'I', 'me', 'you', 'we', 's/he' across the consultations in the corpus. This aspect actually brings out the conversational feature of the consultation making the interaction more relaxed and personal.

The non-standard use of some linguistic features in the HIV/AIDS consultations, illustrate communicative patterns that are characteristic of ELF usage, particularly evident in the use of words. As pointed out in Meierkord (2002: 109-133), in lingua franca situations sometimes, ordinary vocabulary items seem to take on new and/or additional meaning in the interaction and the meaning of some words is shown to shrink. For example in Extract 19 below (*Consultation 3)* the word 'sorry' (line 80) in NS situations usually indicates an apology for wrong doing, but in this case it is meant as a request for clarification. This is typical of South African English even though the same speaker can still use the word to convey its conventional meaning. Also the word 'blood' (83) is an uncountable noun which in this case is modified into an unconventional plural noun 'bloods' to represent the different blood tests to be conducted. Similarly, the patient's use of the

word ‘exactly’ (line 86) in the place of ‘absolutely’ reveals a degree of appropriation of English by the speaker.

Extract 19: Illustrating non-standard use of some lexical items

82	Patient:	Sure
83	Doctor A:	Errhm then we can do the uhm bloods next month hey?’Cos you are almost a year on treatment hey? Just uhm the other thing that I could do, I suspect that that is PPE ok? That’s something that is associated with HIV alright?
84	Patient:	Yes
85	Doctor A:	Uhm. I really don’t think it’s anything more worrying than that. But to be on the safe side we can make an appointment with a skin specialist and they just take a small, small, they take one lesion they take it out, they send it away to the lab, they have a look under the microscope and tell you exactly what it is. Would you like that?
86	Patient:	Yes, exactly

Similarly when the patient says, *“Yes so I file the letter errh this side”* (*line 106, Consultation 8*), he displays a low level of proficiency in ELF as seen in her limited vocabulary because the letter being referred to is a ‘grant application’. In English L1 context the ‘grant application’ and a ‘letter’ semantically refer to two different things meanwhile in this context the term ‘letter’ represents the application and could in fact represent other types of documents. In the same way, Doctor C asks the patient if she got a letter from her former employers to prove that she had worked with them, “*Do you have a letter from them that you’ve done the work?”* (*line 132, Consultation 8*). But it is clear that the letter being referred to is a ‘reference’ or ‘testimonial’. This shows how some words in lingua franca communication expand their meaning and indicates that despite the fact that interactants possess limited vocabulary, they still manage to communicate the core message and get by with less specific vocabulary. The next example sounds like a literal translation from the patient’s L1 because, “*Mara I’ve not finished yet to pay. I still have three months” (line 108, Consultation 8*) is semantically confusing to me as the analyst. To me, it seems the patient is the one paying money but apparently it is clear to the doctor that the patient is referring to maybe the severance payment that she is receiving from the government. These examples indicate that such language use does not really pose any serious threat to the interactants’ understanding as the researcher had originally thought it would because there is mutual understanding in the end. This is

therefore a confirmation and support of the findings of earlier studies by Meierkord (2006a, 2006b) and Firth (1996) that a high degree of co-operation is a typical characteristic of ELF interactions.

5.3.2.2 Code-switching

Before any discussions on code-switching, it is important to note that the researcher has included English translations of the utterances that are produced during an occurrence of code-switching in the HIV/AIDS consultations in this study alongside the original text of each of the consultations at the point in which they occur. But these translations do not have any bearing on the analysis because the researcher does not understand any of the L1s that are spoken and therefore has no access to the information. Besides that, translating the text for analysis would defeat one of the objectives of this study, which is, to investigate how the interactants succeed to communicate with each other without understanding what is said to the other interactants during code-switching. Also apart from the fact that some of the meaning of the text might be lost in translation the selection criteria for participants specifically excluded any consultations using translators or interpreters. Therefore the conclusions drawn from analysing the data on code-switching and its functions in the HIV/AIDS interactions in the study are only inferred from what the interactants actually say in English. However, this would be interesting and a good place to start another study.

Code-witching is a characteristic of lingua franca communication which different authors have explored and emphasised specific aspects in their studies (see Fishman 1971; Gxilishe 1992; Myers-Scotton 2002). Myers-Scotton (2002: 105), for example distinguishes between classic code-switching which occurs when speakers have full access to the morphosyntactic frame of one of the participating languages and composite code-switching which occurs in phenomenon such as attrition and language shift. It has been defined as shifting from one language to another at a lexical, phonemic, semantic or grammatical level (Gxilishe 1992: 93) and as juxtaposition within the same speech exchange of passages of speech belonging to two different grammatical systems or sub-systems (Gumperz 1982: 59). Code-mixing is the embedding of various linguistic units such as affixes, words, phrases and clauses from two distinct grammatical systems within the same sentence and speech event (see section 5.2.3.2 below). However, in the present study the analysis is not going to explore these theoretical differences but consider and identify instances where interactants switch from one language to another within their discourse. The following are extracts and examples showing how this phenomenon occurs during HIV/AIDS in ELF consultations and how it is used by doctors and patients to facilitate their communication. Code-switching is evident in the

present study whereby interactants occasionally switch to their L1 often with another interlocutor outside of their interaction.

According to Gxilishe (1992: 94) code-switching performs different functions such as establishing intra-group solidarity, used for referential purposes and for identification although it is not always easy for the analyst to know the reason why this happens in each case. But some of the reasons can be figured out from the circumstances under which the code-switching occurs as indicated in Extracts 20, 21 and 22. In the data corpus code-switching occurs in 9 of the 19 consultations (see *Consultations 4, 6, 9, 11, 12, 14, 15, 17* and *19*). Code-switching occurs once in Extract 20 (taken *from Consultation 6*) between a patient who later indicated that she could speak the same language as the doctor but opted to use the English lingua franca. This is very interesting because before the consultation the patient gives the impression that she has a different L1 from the doctor and there is no indication if both share any other language. Sharing another indigenous language with the doctor even if this language is not her L1 might have implications for the consultation. This might not necessarily be in terms of quality but in terms of how much was said and the ease with which the consultation is conducted because later, the doctor indicates that the consultation could have been done in another language other than English for their mutual benefit and understanding. The doctor discovers at the tail end of the consultation (*line 93*) that she and the patient could in her opinion have had a better interaction in Sotho. However, it is hard to say if the outcomes of the consultation would have been different had they consulted in Sotho from the beginning. But it is evident that by language switching from English to Sotho the interactants establish some sort of linguistic support and rapport for each other and create an atmosphere of camaraderie that eases the tension and formality of the consultation as evident in (*lines 95-105*). This is the interpersonal/relational function that House and Rehbein (2004: 135) refer to. This indicates solidarity with each other and an assertion of expertise and knowledgeability in the chosen language. Rather than considering this as anomalous behaviour, recourse to code-switching (language-switching) in cross-cultural communication should be seen as evidence of bilingual competence on linguistic as well as social levels (Gxilishe 1992: 94).

Extract 20: code-switching for solidarity

91	Doctor B:	I'm sure that you can arrange it erhm? Are you married to a Mosotho man?
92	Patient:	I was married to a Mosotho man then he passed away
93	Doctor B:	Ooh, can you speak Sotho
94	Patient:	Yes I speak it fluently

95	Doctor B:	Really? ((Addresses her in Sotho: O a bua? –You speak Sotho?))
96	Patient:	((laughs and responds in Sesotho: Ke a bua- I speak Sotho))
97	Doctor B:	Now this lady wants us to speak in English when we could actually speak the language we both understand
98	Patient:	((Laughs)) Eh
99	Doctor B:	(Continues in Sotho: Bana ba gago ba kae- where are your children?)
100	Patient:	((Responds in Sotho: Ba teng, ko skolong- they are here, going to school))
101	Doctor B:	Ok that's nice. Ooh see now, that's why I don't like this tape otherwise we could speak Sotho. Now we are forced to speak
102	Patient:	English
103	Doctor B:	We're forced to speak English because this lady wants to understand us, the researcher wants to understand us
104	Patient:	Uhmm
105	Doctor B:	Alright the next time S we gonna speak Sotho.
106	Patient:	Yeah
107	Doctor B:	When are you planning to be back?
108	Patient:	Errhm I just want to go for Easter and after Easter [I will come back
109	Doctor B:	[You will come back]. Are you taking the kids with?
110	Patient:	Yeah
111	Doctor B:	Ok

The interactants may switch from one language to another because of other reasons such as the referential to convey information, discourse management to clarify something as a repair strategy, highlighting or downplaying ethno linguistic boundaries as well as the purpose of the interaction and to specify the addressee House & Rehbein 2004: 135). These categories of code-switching have been upheld by researchers (see Gxilishe 1992: 93) note that the expressive or directive role of code-switching is linguistic and interactional. The referential function of code-switching is displayed when there is inadequacy of facility in one language on a certain topic or lack of vocabulary to name new things, concepts, persons and personal experiences. This is not a common occurrence in this study but must be mentioned as it is a typical occurrence of congruence in code-switching (Myers-Scotton 2002: 101-102). Only one Xhosa patient uses the expression 'iviral load'

to explain the concept of viral load. This is an element of code-switching and can be seen as a case of borrowing from one language to another.

The expressive function of code-switching is evident when speakers emphasise a mixed identity in order to show solidarity with individuals of both identities and the directive function is evident when code-switching is used to specify the addressee or to deliberately exclude somebody from a conversation (Gxilishe 1992: 94). In Extract 21 (from *Consultation 9)* the doctor occasionally turns her attention from the patient to the nursing sister to get clarity on a patient's medical history in Afrikaans and Xhosa. Such interactions may or may not warrant any contribution from the patient. So the consultation can be interrupted in this way with a number of alternating turns between the doctor and nursing sister in Afrikaans (*lines 24- 65*) or between the patient and the nursing sister in Xhosa (see *Consultation 11*), clearly indicating that the consultation itself is part of an institutional system that involves the collaboration of other medical staff. Code-switching then is sometimes used to facilitate communication between the different interactants when the need arises. The fact that the doctor returns to the use of English when addressing the patient in the last part of line 35 is an invitation for her to join the conversation again indicating that the earlier use of Afrikaans, besides excluding her from the conversation was used for easy communication with the interested party at that time i.e. the nursing sister.

Extract 21: code-switching for referential purposes

21	Doctor A:	But the low blood pressure is NOT to be explained. That might be a delayed effect from the previous drug you were on
22	Patient:	Hmm
23	Doctor A:	Ok?
24	Nursing Sister:	((Speaks in Afrikaans: Dokter, ek soek die… die…-I'm looking for th...the...))
25	Doctor A:	Hmm ((Responds in Afrikaans: …Die groen storie... vra vir Viola. Waar is haar…? Haar?-The green story...ask Viola. Where is her...her...))
26	Nursing Sister:	((Continues in Afrikaans: Dinge s'n is groen, hey?-Hers is green, hey?))
27	Doctor A:	((Responds in Afrikaans: Ja, ek weet nie waar dit is. Dit lyk of die file is weg))
28	Patient:	So my blood pressure is still low?

29	Doctor A:	Your blood pressure is good
30	Patient:	Ooh it's good
31	Doctor A:	Alright? ((Sound of falling instruments)) Ooh
32	Nursing Sister:	(Speaks in Afrikaans: *unclear*)
33	Doctor A:	((Responds in Afrikaans) *Nee, nee* she came with that (Wat is daar bo? Die groen file was nie hier nie, hoor? –what is on there?..The green file was not here, ok?)
34	Nursing Sister:	(Speaks in Afrikaans: *unclear*)
35	Doctor A:	Nee (Speaks in Afrikaans) ok, you have a date on the 8th of April. Can I make it earlier?
36	Patient:	Uhmm
37	Doctor A:	for the 1st, is that alright?
38	Patient:	Ok
39	Doctor A:	((Flipping of pages)) I'm actually very interested in knowing what is going on (0.25). Erhm you just need to your (medicine). Just ask from Sister. It is it is written in here alright? And if you can give this to Sister M (speaking in Afrikaans: Ja ek weet nie waar dit is. Dit lyk of die file is weg-I don't know where it is. It looks as though the file is lost)
40	Nursing Sister:	(Responds in Afrikaans: Dankie, hy's baie...-Thank you, he is very...)
41	Doctor A:	If you can just give that to sister M and she will give you the antibiotic alright?

The use of code-switching for the purpose of identification is evident in Extract 22 (taken from *Consultation 11*). The doctor tries to explain how the CD4 count is done and the implication of the numbers on the health of the patient. Although there is a mix-up with the CD4 and viral load tests, Doctor A notes with satisfaction that she is happy with the improvement of the CD4 count which has risen from 30 to over 270 (*lines 3 & 5*). However, the doctor realises that the patient does not share her excitement about the improved CD4 as the patient pauses a bit in response to the doctor's question in line 3. The patient code-switches to Xhosa and expresses her concerns to the nursing sister because she apparently finds it easier and feels more comfortable explaining them in her L1 to someone who would understand. It is only after this verbal exchange that the doctor who does not understand what the patient is saying in Xhosa enquires to know what the problem is, "*What was*

she saying?" (*line 8*). The nursing sister also reverts to Afrikaans (the doctor's L1), assuming the role of an adhoc interpreter (see Pennycook 1994; House & Rehbein 2004) to express the patient's concern "*Ok, first of all she was asking why the two CD4 counts was two but while she was draw the blood on the same day"* (*line 15*). The doctor then later switches again to English, to explain what had happened in order to allay the patient's worries "*If you take one 5ml, if you take a teaspoon of blood and you take another teaspoon of blood there will be a difference in the CD4 count ok?"* (*line 18*). The explanation is successful because the patient responds with a minimal '*ok*' in lines 17 and 19. Code-switching in this way is a conscious acknowledgement and ownership of their different languages and cultures by the interactants.

Generally, the interactants do not engage in elaborate interaction during code-switching. This is used mainly to clarify something or to request for something. But when it does occur, the normal flow of the interaction is interrupted to accommodate the new participant who is being addressed. By using code-switching in this way the context is emphasised because, "…exactly where the conversation takes place seems to be crucial in that it influences the way the interlocutors perceive the interaction and thus the pragmatic behaviour" (Pölzl & Seidlhofer 2006: 154).

Extract 22: Code-switching for identification

3	Doctor A:	Ok, alright. Errhm, let's have a look, you are exactly one year old on treatment and errh let's have a look here (guess). O:oh alright we did a CD4 count ((bang of door)) last time and the CD4 is 271 and it was done twice. We asked for a CD4 count and a viral load, and instead two CD4s were done. Ok, alright ((chuckles)) that doesn't matter. I think that was done on one day? Nee, this was done last week alright. Ok, so your CD4 is round about 270-280 because the one we did was 271 and the other one is 285 and if we look where it was it came up all the way from 30 in 2007, uhm it came up all the way from 30 in 2007 and was 242 in August, (0.5) alright? So are you happy with that?
4	Patient:	( )
5	Doctor A:	Are you happy with your CD4 of 271
6	Patient:	**(**(speaks in Xhosa: 30? *unclear*))
7	Nursing Sister:	((responds in Xhosa: Uthi isuka ku-30 ngoku (She says it has risen from 30))
8	Doctor A:	What is she saying?

9	Nursing Sister	((Speaks in Afrikaans: this is another sister, *unclear*))
10	Doctor A:	Ok ((responds in Afrikaans: Dankie, hy's baie …. *unclear*))
11	Patient:	((Continues in Xhosa: *unclear*))
12	Doctor A:	( ) ((The script needs to be altered on the green script on envelop))
13	Nursing Sister:	Oh yeah
14	Doctor A:	Ok, thanks alright. What was she saying?
15	Nursing Sister:	Ok, first of all she was asking why the two CD4 counts was two but while she was draw the blood on the same day
16	Doctor A:	Aah it was not on the same day and NOW it was. Ok it, it, we have a lot of variation on, on one day. It might be that this one was done a little bit later, may be an hour later and then you see and blood is not exactly the same you hey?
17	Patient:	Ok
18	Doctor A:	If you take one 5ml, if you take a teaspoon of blood and you take another teaspoon of blood there will be a difference in the CD4 count ok?
19	Patient:	Ok
20	Doctor A:	It's more or less the same, it is over 200. So to me it's a safe CD4 count, alright? We still want it higher but that can take, that can take another year or two even.

5.3.2.3 Hybridisation in the use of lexical items

House (2003: 573) defines hybridisation as anything derived from heterogynous sources. She alludes to Bhabha (1994) who sees hybridity as border-crossing, taking alien items into one's native language and culture, going against conventional rules and standards. In the present study however, this involves the incorporation of linguistic items from the interactants' L1 into English in ELF interactions. It is an aspect of code-switching which involves the isolated use of a lexical items from one language in another because either the speaker "does not know the word for it in the other language or because the language chosen is more fit for talking about a given subject or because a specific word in one of the languages used may be semantically more appropriate for the concept" (Gxilishe 1992: 94). For example, the word '*yho*' occurs three times in my data (*line 95 of Consultation 12, line 28 of Consultation 15 & line 23 of Consultation 18*). It is an interjection that expresses astonishment, surprise and disbelief. It is quite common in normal every day interactions within the South African context and it seems to be a communication feature that has its roots in the

indigenous languages that are spoken in the country. So in the phrase, "*Yho, you are great hey*", the doctor is pleasantly surprised and impressed with the patient's ability to speak many languages (see *Consultation 18, lines 1-23*). Meanwhile 'hey' is a kind of affirmation but quite often it functions as, and is usually placed in the position of a tag question. It appears multiple times in the data and is used quite liberally by all the doctors but more often by Doctor A (*e.g. Consultation 3, lines 67, 77, 83, and 95*). The word '*bietjie'* is an Afrikaans word for 'a little' or 'a bit' and it appears just once in the data (*see line 7 of Consultation 17*). The doctor wanted to know if the patient speaks any Afrikaans and by choosing this word there is the insinuation that if the patient could speak any Afrikaans, then she ought to know the word 'bietjie'. But it seemed that the doctor was deliberately playing on the word for fun because I would think that the doctor knew what English word he could use in place of 'bietjie' in a phrase like "*Not Afrikaans bietjie?*" Other instances of this type of lexical usage are evident in the use of '*vanag*' and '*mos*' in: "*It changed this vanag, it it changed mos*" *(line 14, Consultation 19)* and *"He is a Xhosa mos"* (*Consultation 14, line 156***).** 'Vanag' is an Afrikaans word for 'tonight', while the word 'mos' is a South African colloquialism for 'of course'. The communication in most of the consultations recorded for this study (see *Consultations 1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 17* & *19*) reveals sociolinguistic aspects of the language with the regular occurrence of a local token '*neh*' which is unique to the South African context and used to acknowledge a situation. Evidence from the data reveals that the linguistic feature '*neh*' is used at all the phases of the consultation and by all the doctors, but more frequently by Doctor B (see *Consultations 4, 5, 6, 7* & *12).*

Street names reflect a fusion of both Afrikaans and Xhosa as seen in this example. Although the doctor deliberately chooses the more familiar Afrikaans word 'straat', he could use the English equivalent 'street' to indicate the residential address of the patient. But the doctor's choice can be explained by the fact that the clinic is located in a predominantly Afrikaans area. So the question "*Errhm you're still at Mbongweni Straat"* is still appropriate. In Consultation 4, after the nursing sister laughs off her mistake of not writing down the patient's weight, she code-switches with some urgency from English to Afrikaans (L1) with the words "*kom, kom" that is* 'come, come' (*line 31*) which in this instance serve like an invitation to the patient to do something which in this case is to go and weigh again. This occurs just once. When the patient says *"I'm fine Sisi"* (*Consultation 4, line 10*) she does not imply that the doctor is a 'sister' like the word literally means. The word 'sisi' is a Xhosa politeness term of address used for an age peer who might or might not be a family relation. It signals respect for age, authority and familiarity. So it is therefore not surprising that some patients refer to the female doctors as 'sisi' not necessarily acknowledging seniority of age but quite evidently acknowledging the doctor's seniority of position and authority, particularly in

medical the context. Then, the patient chooses to use the word '*mara*' which functions like a 'but' or 'however' when he says, "*Mara I've not finished yet to pay. I still have three month*s" (*line 108, Consultation 8*). Interestingly, the word occupies the position that the English equivalents would occupy in an L1 situation. The patient incorporates the word 'eish' in "*Eish I don't know doctor*" (*line 118, Consultation 8*) which is an expression that indicates disappointment and/or resignation to a situation that is beyond one's control. This kind of usage gives a contextual feel to ELF in this environment and confirms its variation in terms of the concept of community of practice (House 2003). Such usage does not interfere with the understanding of the interactants involved, presents the speakers as skilled bilinguals and that their levels of proficiency vary but are not in any way deficient.

5.4 A Genre-analysis perspective on the HIV/AIDS consultation

As mentioned earlier (*section 3.3.3*) genre analysis centres around the fact that particular genres are characteristic of certain cultures, and reflect the aims, objectives and constraints of those who practise the cultures. This implies that genre types can be determined by the discourse; the audience and the context in which the discourse is taking place (see Swales 1990; Bhatia 1993; Halmari & Virtanen 2005). However, it is not always easy to delimit genres because they are constantly changing and sometimes more than one genre can be used in the same discourse. Genre analysis is used in the present study to highlight this aspect with regard to HIV/AIDS consultation as part of medical discourse especially to identify some of the different oral genres that are present in the consultation. This will throw light on the nature of linguistic features that characterise the HIV/AIDS consultation. Analyses at the genre level highlight what has been referred to as the 'communicative purpose' which is the 'socially situated practice of using texts with specific intentions' (Hüttner et al. 2009: 102). Therefore the present study conceptualises the HIV/AIDS consultation as medical discourse between doctors and patients that is focussed on the patient's ARV treatment and follow-up and possibly their return to health. Although ELF in this context is not used specifically for HIV/AIDS consultations in the way English for Specific Purposes (ESP) is described in Hüttner et al. (2009), the present study adopts the linguistic dimension of ESP approach which describes the genre in terms of lexis, grammar, patterns of textualisation and the genre-structuring features even though this is not for pedagogic purposes.

Earlier studies have been carried out on the nature of consultation as a genre in spoken language) and researchers do not completely agree on what it actually represents (see Ainsworth-Vaughn 1998; Cordella 2004; Schiffrin et al. 2001. The medical encounter is essentially conversational in

nature. According to Ainsworth-Vaughn (2003: 456), the turn-taking patterns in medical encounters are restricted because of the setting and disparity in levels of knowledge between the interactants and thus are in contrast to those in normal conversational discourse. They further indicate that institutional discourse such as doctor-patient consultations are defined by the restrictions on speech activities because institutional interactions involve specific and significant narrowing and respecifications of the range of options that are available to the interlocutors. It is evident in my study that although the participants are using conversation format their interaction is influenced by the institutional setting and the purpose of the interaction. Thus interactants would normally not engage in the chit-chat of every day conversation and jokes, but would rather focus on the health concerns of the patients and on other topics affecting the patient's health. This however does not mean that jokes and other issues are completely absent from the consultation because the interactants are people after all.

5.4.1 Topic introduction and management to ensure coherence

Topic introduction is a generic marker in medical interviews. Todd and Fisher (1993: 22) point out that, medical interviews that follow a visible written questionnaire format have a rather rigid topic introduction sequence because such interviews specify aspects and topics of the consultation on which the interactants must focus. Topic introduction in the consultations in the present study does not follow any particular sequence since the doctors did not use any questionnaire. The medical interview and the consultations in the present study indicate the location of certain topics within particular sequence types (*section 5.2.2*) and shows that there is a transition between topics. This is the case with the HIV/AIDS consultations because the interactants' primary focus is on treatment, follow-up and to discuss HIV-related issues, even though they discuss other problems which are not health-related. It is for this reason that genre analysis of the HIV/AIDS consultations investigates the types of topics being introduced, at what point of the consultation particular topics are introduced and by whom. The data in this study shows that since the consultations are real life conversations between doctors and patients every consultation is different. Each consultation depends on the patient's history and topic introduction could be restricted depending on the concerns of especially the patients with regard to the ARV treatment which is usually the main topic. In all the 19 consultations, there are seven main themes that come out, six of which were brought up by the doctor and one (i.e. the change of ARV regimen) by the patient. These themes are introduced mostly during the history-taking phase after the greetings sequence and include the following:

i. Patients' complaints come out as main theme (*Consultations 2, 3, 4, 8, 14* & *16* in *lines 3, 3, 3, 17, 5* & *19* respectively);
ii. Starting patients on ARV treatment (*Consutations 1, 7, 12, 13* & *15* in *lines 11, 9, 3, 5* & *11* respectively);
iii. Discussing patients test results and follow-up tests (*Consultations 9, 11* & *19* in *lines 1, 3* & *9* respectively);
iv. Recommencing treatment after non-adherence (*Consultations 5* & *18* in lines *5* & *23* respectively);
v. Change of patient's ARV regimen (*Consultation 17* in *line 18*);
vi. Patients' time schedule for taking ARV (*Consultation 6* in *line 13*); and
vii. Signing work-related documents for patients (*Consultation 10* in *line 1*).

All consultations in this study incorporate the interview and conversation formats, which impact the way the topics are introduced and managed. The general trend indicates that the doctor is often the interviewer and that s/he controls the course of the interaction by deciding what topics s/he introduces and by initiating more topic changes than the patient. This is an indication that the doctor is the person on whose knowledge the consultation turns. According to Shuy, at least three criteria can be used to identify and separate topics from one another namely: difference in subject matter, differences in prosodic features like intonation from the previous topic and the internal cohesion of the topic (Todd & Fisher 1992: 20) Within the main themes in these consultations, different topics are raised (i.e. new issues raised during the consultation. Inspired by the above characterisation of topics I identified a total of 92 different topics in the 19 consultations recorded for this study out of which 70 are introduced by the doctors and only 22 are by the patients. Using Consultation 1 as a case in point, the main theme is starting the patient on ARV treatment. Besides deciding when to start treatment other topics are raised during the consultation. A total of 12 topics are introduced namely:

Topic	**Initiator**
Patient's disclosure of HIV status to partner	Doctor
Patient's impression about ARVs and the need to start treatment	Doctor
The physical examination	Doctor
The TB test	Doctor
History of any pain or irritation in the patient	Doctor
Explanation of the different stages of HIV/AIDS disease	Doctor
Discussion about the patient's belt, its origin and use	Doctor

Decision to start treatment and the implication	Doctor
Patient displacement and implication for treatment	Doctor
The issues around marriage between HIV-positive people	Patient
The issues around childbearing	Patient
Deciding the date for the next visit	Doctor

Ten of the topics are introduced by the doctor and only two of these are introduced by the patient and this is done almost at the end of the consultation when apparently the doctor has exhausted his own topics. The doctor introduces the topic of patient's disclosure to his partner as early as line 7 "*So you did speak to her about HIV but you didn't tell her about your status*?" (*Consultation 1*), but does not say much of the patient's response in line 8, which is negative. Instead, the doctor goes straight to the next topic and what she considers to be more important, that is, the patient's impression of ARVs and his readiness to start treatment (*line* 9). Then after discussing the patient's fear and reassuring him the doctor introduces the next topic which involves the physical examination, "*Ok S just quickly come over here. Would you like to sit on the b:e:d and let me quickly have a look at you? Can I can I quickly just have a look at you*?" (*line 2*3). This pattern of the doctor introducing new topic continues until apparently she has finished her topics and ended the counsel she was giving him. The patient takes the cue to introduce his topic from the fact that the doctor is through with the advice on not waiting for too long to start the ARVs (*lines 92, 95 & 97*). It is only at this point that the patient feels it is alright for him to raise his personal worry. This is evidence that the introduction of topics in the consultation is not balanced.

However, some consultations highlight the fact that patients do initiate topics albeit sparingly. Of the eight topics introduced in Consultation 4, only one was introduced by the patient (see *Consultation 4, lines 54, 56 & 60*) where the patient takes the initiative. In all the cases where the patient introduces a new topic the issues raised are both complex and of a very personal nature but which they really want the doctor to give them some clarification on. It could be something they are trying to understand, for example, how does an HIV-positive person go about getting a wife or having children? The evidence across the data indicates that most of the initial talk and topic changes are introduced by the doctor and the patient only makes a topic change when prompted by the doctor (see *Consultations 2, 4 & 8*) or for very personal issues as already stated. This topic change pattern is characteristic of consultations in general as it attests to the doctors' authority and knowledgeability but it is certainly not a peculiarity of ELF interactions even though one could say that the ease with which the participants engage in topic change is indicative of their level of proficiency in ELF. Topic change and abandonment are sometimes used as communicative strategies in ELF interactions to circumvent certain instances of misunderstanding (see *section 5.2.3*

above). It is a fact however that the authority and control displayed by the doctors in the introduction and management of new topics in this way during consultation can be attributed to their possession of exclusive knowledge gained through years of training and exposure to English.

Furthermore, because the patient is desperate to be understood s/he discusses and expands on any topic the doctor introduces because any such topic is deemed to have some relevance and significance to the patients' health and their coping with HIV/AIDS disease. This happens when the doctor asks for the patient's perspective on a specific topic like one would do in a conversation. This gives the patient the opportunity to digress a little from the medical issues into socio-economic concerns. Although Doctor C already knows that HIV causes weight loss among other things in many patients, he wants to find out if the patient is able to attribute some of their physical changes in their bodies to their HIV-positive status when he asks, *"...So since then up till now what happened? Did you see anything different in your body?"* (*line 35, Consultation 15*). When Patient 2 says she has lost weight (*line 36*) and this is confirmed by Patient's 1 comment that "*she was fat"* (*line 39*), the doctor then uses the patients' perspective as displayed in their answers to co-construct and elaborately formulate the impact of the HIV virus on the human body thus:

"*Is it? Ok. We know that when there is HIV in your blood it uses a lot of your energy because remember in one person with HIV there is as many viruses in the body as there are people on the earth. So they take all your energy and sometimes people lose a lot of weight. The other thing why people lose weight is with HIV is that they need to be careful that they don't develop TB. So we also need to check the TB. There are two reasons why people lose weight that is, the viruses are many of them they use a lot of energy and the other thing is that when you have TB is another reason. But I've not seen any TB on you; I haven't picked up any TB on you. You never had TB before* (*line 40*).

This is contrary to the view expressed in earlier research which found that the patient is not expected to expand, amend, ignore or disagree with a topic introduced by the doctor in the medical interview; rather their only option is to request clarification, agree or directly express uncertainty and hesitation (Todd & Fisher 1993: 24). Evidence from my data indicates that some assertive patients initiate topic changes because they wish to bring particular health concerns to the knowledge of the doctor or request clarification on an issue that has already been discussed but which they did not understand. For example in Consultation 14 (*lines 22* & *24)*, the patient immediately introduces the problem with her skin, "*First thing it's my skin. I have a skin problem"* (*line 22*) and *"I don't know what is the problem, from December I've got these pimples"* (*line 24*). Then, she poses the problem of her sore feet, *"Every morning it's sore, they are sore"* (*line 54*) and goes on to reveal her main problem which is the cessation of her menstrual period, *"The main*

problem, I haven't seen…but I'm not pregnant. I haven't seen my period for I think about five or six months…" (*line 76)*. This linguistic assertiveness, albeit infrequent in medical interactions is a behaviour that is applauded by medical researchers (Pendleton & Hasler 1983; Mead & Bower 2002) and even more so in the South African context which was noted in the past Apartheid regime to have deprived especially the African patients of their initiative for communication in all aspects of life even the health worker-patient relationship (Ellis 2004: 44). This is appreciated by the doctor in this case, as he takes time to explain the implications of the patient's experience thus:

"*Yeah, well, people can have menopause at at forty at forty but err we need to check and the other thing that happens is sometimes when people get sick, very sick, they also have a problem. They can also stop menstruating. It's the body you know, some people that have lost weight. We see a lot of people with HIV just because they are sick they are missing [their…"* (*line 85*).

The communicative behaviour revealed in topic initiation in the present study are indicative of the fact that patients are beginning to become more aware of their rights to quality health care and their responsibility to partner with the doctors to negotiate and take charge of their own health and wellbeing despite the gap in proficiency and knowledge.

Since the doctors need information from the patients on the various HIV-related issues in order to effectively play their roles as educators and doctors, they are almost bound by the situation to introduce the topics that in their opinion are relevant to the consultation. Thus they can refer to a topic which had been discussed or mentioned earlier through anaphoric reference. By so doing they ensure coherence in topic shifts during the consultation to keep the interaction unified, focused and meaningful. It has been shown that coherence in topic shifts is established through referential links between any topic and the underlying medical purpose of the interaction (Wynn 1995: 97). Such cohesion is evident in the linguistic structure of the interaction in the use of anaphoric pronouns, repetition, closely related words and synonyms and has interactional significance. In Consultation 1 some linguistic reference is established in the cohesion of topics. When Doctor A asks the question: "*When was your test?"* (*line 29*), the patient understands through anaphoric reference to the topic that the test being referred to is the TB test mentioned earlier in, *"Did you do your TB test as well?"* (*line 27*). This explains the patient's response, "*Two or three years"* (*line 30*). Also in Consultation 3, the patient informs the doctor of the blood that was found in his urine "*Errh she she said in my blood, sorry, in my urine she noticed noticed some blood*" (*line 4*) and the doctor uses the pronoun 'it' to refer to the blood in line 5.

Beside topic initiation I identified strategies that the interactants in HIV/AIDS medical consultations in ELF achieved coherence within topics. Meierkord (2006b: 24) investigated this

aspect and observed that interlocutors in cross-cultural ELF interactions employ pragmatic strategies such as topicalisation through the movement of focused information to the front of the utterance to enable them focus on each move as if it were a new topic. This facilitates communication and ensures understanding. These strategies include the recycling of a specific topic regardless of where it occurs or how much the interaction has progressed and the echoing of the previous speaker's statement with the purpose of affirming their contribution to the interaction. The results from my study support these observations as there are indeed instances of topic recycling, echoing and repetition in some of the consultations. Other strategies such as repetition through paraphrasing and the use of related words which the interactants use to properly manage the topics in the consultation can be identified. For example in Extract 23 (taken from *Consultation 1*), the doctor initiates three topics: the patient's feelings about ARVs, the knowledge he has acquired from counselling about ARVs and his decision to start the treatment (*line 9*). From the dialogue that follows the doctor repeats one of the questions, "*What is your feeling about it?"* (*line 11*) in order to focus the patient's attention on what she really needs to know. Then from line 12 the patient expresses some reservations about the duration of treatment and the quantity of pills he has to take. The doctor echoes and affirms this fear in lines 13, 15 and 19 but both come to the conclusion that in spite of this fear, the patient is determined to take the treatment as seen in the statements: "*That is why I'm not feeling so good but it's nothing it's part of life I can carry"* (*line 18*) and, "*But on the other hand you want to"* (*line 21*). Interactions such as this one attest not only to the fact that ELF interactants aim at negotiating meaning to come to a level of mutual understanding but also to the nature of consultation as genre whereby the doctor has to use all means possible to make the patient understand what s/he is saying.

Extract 23: Topic echoing and recycling

9	Doctor A:	Ok alright ok oh how do you feel about ARVs because I see P has been giving you counselling about ARVs :::? A::nd she spoke to you about having to start ARVs?
10	Patient:	Y:e:s, yes
11	Doctor A:	What is your feeling about it?
12	Patient:	A:i:I just because I:: wow I eish you never stop errh to to of drinking the ARVs I refuse of it b'cos I can't eat errh carry on I can't eat errh so much errh a lot of errh of- of tablets 'cos sometimes errh I can't say agh errh I can't eat it I can't drink it but I will try that is why I feel so bad
13	Doctor A:	Are you worried about …

14	Patient:	Ye::ah and…
15	Doctor A:	the lots of tablets because it's gonna be five tablets a day eh?
16	Patient:	then I was going to take it a long may be the whole life y'see
17	Doctor A:	Y:e:s, yes it's lifeline
18	Patient:	That is why I'm not feeling so good but it's nothing it's part of life I can carry
19	Doctor A:	Ok so you have this fear about going on this treatment fi::ve tablets a day for the re::st of your life eh?
20	Patient:	I can't do it
21	Doctor A:	But on the other hand you want to

Another topic management strategy that is evident in this data is repetition through paraphrasing and the use of related words. For example, in Extract 24 (*Consultation 4*) the doctor introduces the topic of problems encountered by the patient while on treatment in the question, *"No problems?"* (*line 17*). But from the patient's response "*No problems doctor"* (*line 18*), the doctor realises that she has to be more explicit as to what 'problems' she is talking about because she expects the patient to have some problems. So she paraphrases her previous statement by giving an example of such problems in her next question "*You are not losing weight?"* (*line 19*). This leads the patient immediately to respond that he is coughing "*No, agh-agh but I am coughing now. But I need a syrup for coughing*" (*line 20*). After a brief discussion of the TB test, the doctor introduces the topic of the duration of the cough by affirming and repeating the patient's response (*line 25*). In an effort to get the patient to understand what else could constitute the 'problems' she asked in line 17, the doctor introduces the topic of weight loss again in, "*…but are you not losing weight?"* (*line 25*). Despite the patient's negative replies (*lines 26* & *28*) to this question, the doctor wants to be sure of the accuracy of these replies and so she ignores the patient's answers and insists on being told the weight as of that day, by repeating and recycling the question "*How much was your weight today?*" in lines 32, 34 and 36. Examples like these are many and recurrent in these data and attest to the fact that although the participants come from different cultural backgrounds they adopt strategies such as collaboration and negotiation of meaning in their interactions.

Extract 24: Topic repetition through paraphrasing

17	Doctor B:	No problems?
18	Patient:	No problems doctor
19	Doctor B:	You are not losing weight?
20	Patient:	No, agh-agh but I am coughing now. But I need a syrup for

		coughing
21	Doctor B:	We don't keep syrups for coughing. What comes out when you cough?
22	Patient:	Now not today, I make a test for TB and spit out. I am still waiting for the result but I think that the result is supposed to be out next week but I am not sure
23	Doctor:	Uh:m? But how long are you coughing now?
24	Patient:	I have two weeks now
25	Doctor B:	Uh::m for two weeks but are you losing any weight?
26	Patient:	Nothing, agh agh but especially in the night
27	Doctor B:	Uhm, ok but you are not losing weight, are you?
28	Patient:	Agh-agh
29	Doctor B:	What is the weight? Sister N we didn't weigh you
30	Patient:	We did
31	Nursing Sister:	I did ((laughs)) Ho-ho, didn't I write it? Kom kom
32	Patient:	How much was your weight today? Did you weigh?
33	Nursing Sister:	I weighed her
34	Doctor B:	How much did you-she
35	Nursing Sister:	Seventy-six, sixty-nine, seventy-nine
36	Doctor B:	But how much was it today, do you remember?
37	Patient:	Agh-agh I couldn't tell her
38	Nursing Sister:	I wrote it ((laughs)) ( )
39	Doctor B:	She is going to weigh
40	Patient:	Oh ok
41	Doctor B:	Ok so your weight has come down a little bit. So we'll have to wait for the for the sputum results hmm?
42	Patient:	Yes, yes, I'm still waiting

HIV/AIDS consultations entail the need to monitor and control the virus, and thus the patients' visits to the facility have a temporal structure meaning that the consultation is far more frequent and regulated time wise than in consultations of patients with ordinary health conditions. This is because the doctors are required to see and assess the progress and adherence of the patients to ARV treatment at specific intervals. This explains why the doctors in the consultations are seen to be very particular about and emphasise the dates of certain tests and dates for the next visit. In 16 of

the 19 recorded consultations, date and time constitute a big part of the consultation. This aspect is a generic feature that also impacts on the structure of the interaction.

5.4.2 Response solicitation and the use of questions

Questions are one of the linguistic features that characterise the consultations in my study and are typical of medical interviews. They have been identified as one of the central variables in conversation analysis of doctor-patient interaction especially in studies that investigate issues of power (Wynn 1995). Results from the present study indicate that doctors ask more questions than the patients and that physician-initiated questions function as a means of controlling the course and content of the interaction. The focus of this research is more on the structure and use of questions by both doctors and patients as a means of requesting and getting information relevant to the health condition of the patient and as a means of requesting clarification during the consultation as seen in Extract 25 (*Consultation 17*). For example in line 19, Doctor C points out that the patient's medication has been changed but wants to know the patient's reaction to this. So he poses the question, "*And how do you feel? Is that not too strong for you"* (*line 21*). This gives the patient the opportunity to give his perspective of his experience, "*No it's right"* (*line 22*). Similarly, after stating the concern of the other doctor about the change in the patient's body, he wants to know from the patient what exactly the problem was. So he asks the question, "*What was the problem with your body?"*(*line 23*). The patient then explains, "*The weight, losing the weight when I was using that one"* (*line 24*). He goes on to ask the patient about the way he is coping on the new prescription in another open-ended question so that the patient has the opportunity to state any difficulties. Fortunately, the patient is happy as indicated in his response, "*It's very easy that one"* (*line 32*).

Extract 25: Doctor's use of open-ended questions

15	Doctor C:	So how are you doing, how are you feeling?
16	Patient:	I am feeling alright now
17	Doctor C:	Is it?
18	Patient:	It's better to change that ((I mean the last one))
19	Doctor C:	Is it? So they started you with a new one
20	Patient:	Yes last month
21	Doctor C:	And how do you feel? Is that not too strong for you?
22	Patient:	No it's right
23	Doctor C:	Is it? They were worried about your body changing. What was

		the problem with your body?
24	Patient:	The weight, losing the weight when I was using that one
25	Doctor C:	Is it, is it?
26	Patient:	Yes
27	Doctor C:	Ok, ok you were losing weight and they were worried about the acids were coming into your body and things like that. Now you are taking only the tablets. Let me see what they have done, so you are taking the one in the night
28	Patient:	Yes only in the night
29	Doctor C:	You now take all three just at night
30	Patient:	Yes
31	Doctor C:	Is that easy or it's difficult?
32	Patient:	It's very easy that one

The definition of 'question' as "a group of words addressed to a person in order to elicit information or evoke a response" or "an interrogative sentence" (Wynn 1995: 84), presupposes that a question can be formulated in ways other than complete sentences. In the present study questions appear in different forms, ranging from standard questions such as the doctor's "*Did you tell her that you are HIV-positive? Does she know?"* (*line 61, Consultation 7*) and the *"How are you?"* that characterises the greeting sequences in most of the consultations to elaborate interrogative statements by the doctor such as, *"Ok I mean you don't, before the last month you haven't taken them eh?"* (*line 29, Consultation 3*) and *"Today, what did you what did you weigh today because I think they forgot to write here. Do you remember?"* (*line 123, Consultation 7*). There is evidence of the subject-inversion questions such as the doctor's, "*Anything you want to ask me?"* (*Consultation 2, line 41*) and the Wh-question type, for example "…*What was the reason for your weight do you know?"* (*Consultation 15, lines 11-12*). These findings are contrary to Wynn's opinion that in conversation complete interrogative sentences are uncommon and that questions are normally identified in relation to their contexts. It has been noted that physicians have to be attentive to developing and refreshing their communication skills by using a patient-centred approach of allowing the patient to tell the story while at the same time guiding them to provide pertinent details and information (Mead & Bower 2002; Oates et al. 2000). The open-ended questions are very useful in the consultation because they open up the consultation from the perspective of the patient.

The study further indicates frequent use of closed questions especially in situations where the doctor wants specific answers. This is a strategy that has been reported to be useful too in the

solicitation of response, information and clarification through questions is a common linguistic feature in doctor-patient communication (see Barrier et al. 2003) because it gives no room for digression. Closed questions occur multiple times in these data (see *Consultation 7 lines 3-8; 11 lines 42-45, 50-53 & 102-105; Consultation 15 lines 7-10; Consultation 16 lines 3-6 & Consultation 17 lines 1-4*). In the example from Consultation 7, Doctor B wants specific information regarding the patient's readiness to start ARV and so she seeks this information through closed questions (e.g. "*Ok, are you ready to start treatment today? Are you ready to start with your ARVs today?"*(*line 3*) until she gets the answer she wants '*yeah*' (*line 8*). Watermeyer et al. (2009: 2057) point out in their study of pharmacist-patient interaction observe that questions might be repeated and rephrased in order to enable the recipient (often the patient) to provide a response.

With regard to the use of questions in the consultations my study shows that even though the doctors are in command and ask more questions than their patients, some few patients do ask questions (see *Consultations 4, 8 &14*) and that those who do ask questions get more information and get more of their concerns addressed as evident in the length and content of their consultations. For example, questions such as "*So that's what I wanted the doctor to check whether it's the change of life or what is it because I am"* (*line 78, Consultation 14*) highlight unique and quite personal problems. Previous research indicates that patients express more of their concerns and anxieties by asking questions (Street 1991: 908). Street noted that cancer and female patients asked more questions than their male counterparts. Although this is an HIV-related study, this is found to be true from my data in which majority of the participants are women and they seem to be more open to asking questions about their concerns than the men. The results further confirmed the reluctance on some patient's part to ask questions as had been reported in earlier studies (e.g. Roter & Hall 1992), because there is evidence in my data of some patients who ask questions only when they are invited to. An example is Doctor A's question "…So errh, any other problems that you are having?" (*line 36, Consultation 11*) which is immediately followed by the patient's complaint about his eyes and the fact that he does not see properly "*I don't see properly*" (*line 40, Consultation 11*). For more of such examples see Consultation 2 (*lines 41-4*)*;* Consultation 11 (*line 78*)*;* Consultation 15 (*lines 113-114*)*;* Consultation 17 (*lines 97-98*) and Consultation 19 (*line 31*). When a patient declines an invitation to ask a question the doctor regains control of the interaction as evident in Consultation 13. After discussing the patient's medical history Doctor B extends an invitation to ask any question "*Ok alright, anything problems today?"* (*line 31*). When the patient says "Oh no" (*line 32*), the doctor immediately claims the floor and announces her intention "*Hmm, so today we are just going to examine you to make sure that everything is fine, order your new treatment and in*

two weeks you can come and start your treatment neh?" (*line 33*). Also see line 41 and the dialogue that follows. It is interesting that the doctor always knows what to ask the patient in such instances.

Some of my results reveal requests from patients phrased as statements in which the patient expresses a wish. In Consultation 4, the patient says, "*No, agh-agh, I am coughing now. But I will need a syrup for coughing"* (*line 20*) and the doctor responds, "*We don't keep syrups for coughing"* (*line 21*). Unfortunately, this expectation expressed in a request results in what appears to be a territorial battle between the doctor and the patient in which although the doctor acknowledges that it is her responsibility to perform diagnosis, her response seems to suggest to the patient that making diagnosis and giving prescriptions is the doctor's jurisdiction and that the patient might not venture into this territory. Although patients have been reported to sometimes use the question format to display their expectation of the doctor's responsibility to perform diagnosis of their troubles (Perakyla 1997: 205), this apparently does not augur well with the doctor. It is not clear whether the doctor is not happy with the patient's suggestion but her response apparently puts the patient in check as he does not make any such requests again. Both closed and open-ended questions feature prominently across the data in question-answer sequences relating to issues on HIV/AIDS and ARV treatment such as when the patient started treatment, how long s/he has been on ARVs, how well they are coping on ARVs, if they are adhering to treatment, if they are married or if they have children.

5.4.3 The HIV/AIDS consultation as story-telling

Illness narratives are stories about illness told by the ill persons themselves as opposed to narratives about illness told by medical professionals (Hydén & Bülow 2006: 698). They have often been seen to represent the two voices, that is, the voice of the lifeworld and the voice of medicine both of which often conflict because the medical professionals view illness, health and treatment differently (see Mishler 1984; Hydén & Bülow 2006). It has been noted that "many ill people find they cannot live the story , or just the story, that biomedicine tells of their illnesses; the need for a voice of one's own is a particularity of our times" (Frank 1997: 31, cited in Hydén & Bülow 2006: 698). A number of uses have been attributed to illness narratives one of which is the fact that it helps the ill person construct a new identity through telling about themselves, their lives, and the form of illness with other sufferers. The consultations in the present study are considered as such narratives and the interest here is to see how the stories are told in the HIV/AIDS consultations as patients present their health concerns and symptoms to the doctors.

HIV/AIDS consultations reveal a multi-faceted dimension that comes through in the discourse through the mixture of different kinds of conversation as a feature of this genre. Due to the nature of the consultation there is little evidence of story-telling. This is because most of the patients at this point are confirmed to be HIV-positive and are already on or beginning treatment. So they have gone past the initial stage of shock and the need to unburden themselves in telling their story. Consequently, the story-telling part of the consultation is minimal and the participants, especially the patients try to prioritise their problems. The real problem at this point is how to tackle other health problems that the patient presents with and to determine if the patient's ARV treatment is going well. However, in almost all the consultations in the present study there are instances in which the patients can be said to be telling a story as they recount their experiences with some of their symptoms and how they are coping on treatment or how the ARVs are changing their lives. Even though they do not set out to tell a story, the participants' utterances when combined, actually do tell a story as the topics link up to one another in a systematic manner. In Extract 26 (taken from *Consultation 14*) for example, the patient recounts a series of health problems and explains how she has been trying to manage them and the effect this is having on her life. Stories like this one reveal how interactants feel about themselves in terms of how the disease has affected their sense of identity, like when the patient says, "*No, doctor but they spoil my face"* (*line 44*) *and "I don't want to look like this"* (*line 46*).

Extract 26 (*Consultation 14*) further reveals the assertiveness of some patients. Notice how open and forthcoming this patient is with her medical problems some of which are not necessarily HIV-related but which could impact on the ARV treatment (see *the skin problem in line 22*). In this extract the patient presents her problems immediately after the greeting sequence seemingly in descending order with regards to the severity of the situation and how much she is worried by it. She identifies a problem (*line 22*) and explains for how long she has had the problem, "*I don't know what is the problem, from December I've got these pimples"* (*line 24*). She explains the seriousness of the skin problem and how she feels now that she is on treatment, "*Yes but now they are much better because Sister M gave me errhm Aqueous cream"* (*line 28*), but also expresses her frustration at the level of success she is getting after, *"I wash myself with Aqueous cream and I smell Aqueous cream but they don't go away"* (*line 30*). Her story continues to the problems with her feet: "*Every morning it's sore, they are sore"* (*line 54*) and again with her frustration with the treatment "*Sister M was giving me pills but they don't help me"* (*line 62*). The consultation continues with the patient telling the story of her other health problems (see *Consultation 14 for the rest of her story*). The gravity of the situation is signalled by her emphasis (shown in the transcripts by the use of capital letters *lines 22, 26* & *34)*. The doctor's back channelled *"Uhmm"* (*line 23*) is a pragmatic strategy

indicating an acknowledgement of the patient's right to the floor and may be an indication that Doctor C is soliciting more information about the problem through prompting. This is a cue which the patient picks up and of course goes on to explain to the doctor when the skin problem actually started (*line 24*). In this way some form of social order is interactionally established, in which the doctor's authority is affirmed by his directing the course of the consultation and asking the questions while the patient yields to this questioning and provides the information the doctor wants. Examples like this are present in all the consultations except Appendix 10 because no health issue is discussed during that consultation. They however vary with the circumstances of the patient involved in each of the individual consultations.

Extract 26: The HIV/AIDS consultation as a story

22	Patient:	First thing it's MY SKIN. I have a SKIN PROBLEM
23	Doctor C:	Uhmm
24	Patient:	I don't know what is the problem, from December I've got these pimples
25	Doctor C:	And that's new, you haven't had them before
26	Patient:	No and they were BAD
27	Doctor C:	Is it, is it?
28	Patient:	Yes but now they are much better because Sister M gave me errhm Aqueous cream
29	Doctor C:	Hmm
30	Patient:	I wash myself with Aqueous cream and I smell Aqueous cream but they don't go away
31	Doctor C:	Do you still see new ones?
32	Patient:	Yes like this one
33	Doctor C:	There are still new ones?
34	Patient:	YE::S
35	Doctor C:	I just want to see.
36	Patient:	Like these ones
37	Doctor C:	And then is there pus in it, is that white stuff in it?
38	Patient:	No
39	Doctor C:	Is it? Hmm, hmm.
40	Patient:	Hmm they are sore
41	Doctor C:	Yeah but you don't like the colour, they change your face. You are like a teenager again.

42	Patient:	No
43	Doctor C:	You don't want to be teenager again?
44	Patient:	No::, doctor but they spoil my face
45	Doctor C:	Yes, yes.
46	Patient:	I don't want to look like this
47	Doctor C:	You don't want to look like this
48	Patient:	No doctor
49	Doctor C:	Ok, ok so I just want to write down [the skin
50	Patient:	[And the other thing
51	Doctor C:	Ye:s?
52	Patient:	My feet
53	Doctor C:	Hmm
54	Patient:	Every morning it's sore, they are sore.
55	Doctor C:	Is it like pins and needles?
56	Patient:	Yes every morning when I wake up
57	Doctor C:	Is it?
58	Patient:	Yes
59	Doctor C:	Uhmm and you had that before or are it's getting worse now?
60	Patient:	It's getting worse.
61	Doctor C:	Is it?
62	Patient:	Sister M was giving me pills but they DON'T HELP me
63	Doctor C:	Is it? They've explained to you where it comes from, hey?
64	Patient:	Yes
65	Doctor C:	It's the small nerves in the feet that get damaged and things like that

Stories like this one are used to portray the self because the speaker constructs her identity through the events inside the story (Ainsworth-Vaughn 1998: 152-153). The medical discourses perceived as stories frame not only the participants as doctors and patients but the discussion of the disease as well. It introduces a diagnosis and validates a patient's experience through dialogue as seen in the example above. Doctors and patients use stories to propose, argue against, augment or accept a diagnosis and its associated treatment plan (Ainsworth-Vaughn 2003: 463). For instance, when the patient declares, '*Sister M was giving me pills but they don't help me'* (*line 62*), the doctor takes over to explain why 'It's the small nerves in the feet that get damaged and things like that' (*line 65*). It has been suggested by proponents of patient-centred approaches (e.g. Mead & Bower 2002)that

doctors allow patients to tell their story as much as possible, making few interruptions and cut-offs. This can be done by the doctor occasionally avoiding to return to the technical aspect of the infection which is usually complicated for most patients. The story presents the patient's 'life world' as he/she tells his experience.

5.5 The impact of the institutional context on the HIV/AIDS consultation

From the institutional perspective, due to the multifaceted nature of the HIV/AIDS treatment the visit is segmented into different phases and the patients are required to go through various checks before they ever get to the consultation itself. For example, after the formalities with the receptionist the patients have to go to see an adherence counsellor for what the 'pills count'. After that, they go to the nursing sister for the following: to be weighed, for their blood pressure to be taken and for blood to be drawn for any test(s) that are required. Some of the patients are referred to the dietician for nutrition advice which can help them generate maximum benefits from their ARV treatment. It is only then that they are allowed to consult with the doctor and the dialogue that ensues linguistically attests to this context. This institutional set up though not a language issue in itself, could affect the doctor-patient interactions in the sense that some of the doctors would rush the consultation as seen in Consultations 2, 5, 9, 13, and 19, and fail to engage at the interpersonal level as expected with the patients during the consultation. This reduces the consultation to the much criticised bio-medical perspective of the doctor-patient consultation and further limits any chances that the interactants could have had to talk more. In Consultation 9 for example, the doctor omits the pleasantries of greeting sequence and goes straight into giving the patient information about his condition, "*....it is puzzling the fact that your HB, your red blood cells, alright, your oxygen carriers , that they are dropping so quickly...*" (*lines 3* & *5*). This can be explained partly by the urgency of the situation and the fact that the doctor is really worried about the patient's state of health as well as the fact that the patient might have spent much time following the clinic protocol.

5.6 Summary

This chapter has given an analysis and discussion of the data using extracts from the different consultations. The analysis identifies the linguistic and discursive features that characterise the HIV/AIDS consultations in the study. The analysis is informed by the theories that provided a framework for the study, that is, CA, DA and genre theory. First, from the CA perspective, the study identifies linguistic features such as turns and sequences, highlighting their allocation patterns and organisational structures. It highlights the fact that there are different types of sequences that

characterise different phases of the HIV/AIDS consultations. The way in which different repair strategies are used to resolve misunderstanding during the consultations is discussed. From a DA perspective, the chapter identifies discursive interactional features of the consultations. It tries to consider which features are typically used in ELF communication, and which are typical of the consultation genre, regardless of the linguistic medium. It highlights how this setting affects aspects of the consultation such as turn-taking patterns, sequences and repair. The different socio-cultural backgrounds of the interactants and the institutional context of the consultations were explicated to illustrate the connection between language, discourse type and context. In this light the chapter discusses participants' description of various topics, such as the medication and HIV-related conditions they need to raise in consultation with a doctor and the cohesion between these topics. Meanwhile, communicative strategies such as the use of detailed explanation, analogy and metaphor as well as code-switching were discussed. The consultations are characterised by the use of communicative strategies such as detailed explanation, the use of local imagery, hybridity and indigenisation, code-switching and lexical transference and borrowing. The use of specific oral genres such as questions and story-telling within the consultation were identified. Some of the linguistic features highlighted participants' different levels of familiarity with the communicative context and awareness of the communicative fragility of the HIV/AIDS consultation which is dealing with a life-threatening disease. These features reveal the co-operative, consensus-driven and collaborative nature of ELF interactions which respond to the participants' awareness of the sensitive and delicate nature of their communicative encounter. The discussion shows that participants are resourceful in using ELF. Finally, the chapter discusses the HIV/AIDS consultation as part of the medical discourse genre in an institutional setting.

CHAPTER SIX
GENERAL CONCLUSION

6.1 Introduction

This study has explored the linguistic and discursive features of interactions between doctors and HIV-positive patients with different L1s and has considered how they use ELF to communicate and resolve misunderstanding during consultation. In particular, the study identifies and analyses the particular linguistic and discursive features that characterise HIV/AIDS consultations conducted in ELF where the English proficiency of the participants is varied and where pragmatic competence in the context is dissimilar among the participants. The study discusses different conceptualisations of ELF and adopts the one that views ELF as a medium in a community of practice as the one suitable for the study. It further identifies research trends and recent interests in ELF research. The study identifies CA, DA and genre theory as theories that provide the theoretical framework and audio-recording as the method used. This chapter will indicate how the theoretical framework was applied in analysing the data and will consider how well-suited it was to achieve the objectives. It will illustrate how the key findings address the research questions and give an indication of the extent to which they validate or invalidate the hypotheses with which the study started out. The chapter highlights the impact the study could have on theoretical questions of ELF-research, on the research field of HIV-communication and of medical consultation from a communicative and discursive perspective. It further highlights the benefits that could be derived from this kind of analysis of doctor-patient interactions in terms of policy-making. Some of the shortcomings and challenges of the study in terms of method, data and matters that impacted on the findings are pointed out. Finally the researcher makes some recommendations for further research. Thus this section provides an overview of the study.

6.2. The theoretical approach adopted in the study

Referring to established pragmatic theories that describe and explain the structure and use of oral communication and thematically specific discourses, the present study uses analytical instruments of CA, DA and genre analysis complementarily to investigate the use of English as a lingua franca in medical consultation in a context unique to HIV-health care in a small number of South African day clinics. This complementary approach makes it possible to link certain micro and macro aspects of language use in these HIV/AIDS consultations as suggested in the central theoretical approaches of this research, namely CA and DA. The CA perspective explores interactional features of oral

communication of a relatively informal kind, considering the organisation of conversation as it becomes apparent in units such as turns and sequences. Different repair strategies used to achieve communicative success or to resolve misunderstanding in the consultations are attended to. The DA perspective draws attention to the coherence in the HIV/AIDS discourses, considering formal and contextual devices on which interactants rely when they use English as lingua franca to establish cohesion. Evidence in this study shows that coherence is achieved through the use of anaphoric reference in articles and pronouns (see *Consultation 1*), the use of topic repetition and echoing (see section 5.4.1**)**. Significant aspects of the socio-cultural context and the institutional setting in which HIV/AIDS care is given in a number of semi-rural day clinics in the Western Cape are pointed out.

CA and DA enabled the researcher to identify communicative features such as indigenisation (*section 5.3.2*). Strategic uses of local metaphor and analogy (*section 5.3.1.2*), strengthened by practices of detailed explanation (*section 5.3.1.1*), code-switching (*section 5.3.2.2*) and lexical borrowing of words such as 'iviral load' and in particles like '*neh*' and '*mos*' were given dedicated attention. Genre theory attempts to characterise HIV/AIDS consultations as oral medical discourses (section 5.4). It enabled the researcher to categorise HIV/AIDS consultation as a sub-genre of medical discourse, and then particularly one that is mixed in that features of different kinds of discourses are used jointly. The purpose of the interactions, which involves a doctor and patient discussing health problems, giving (and receiving) a diagnosis, implementing a treatment plan and attending to adherence issues, co-determine the structure of the discourses in case. Thus the HIV/AIDS consultations are constituted by a mix of features typically used in oral genres such as interviews which involve questions and answers, story-telling and rituals. During the HIV/AIDS consultations, the use of open-ended questions by doctors allow for the production of more spontaneous and lengthy responses by patients. This often results in the production of narratives which give the doctor access to more information he may require in planning the medication and treatment protocol of a given patient.

Story-telling (see *section 5.4.3*) is a genre widely used outside of the medical context – thus one to which all interactants have access. This helps to develop a holistic picture of the patient's health. The HIV/AIDS consultation is portrayed as a ritualised activity where the standard practice is to have two participants and in given circumstances three participants (e.g. when a nurse or other health care provider is present). The ritual is constituted of a sequence of specific activities such as history-taking, physical examination, tests, diagnosis, prescription and dosage instructions. Although the HIV/AIDS consultation is portrayed as a ritualised activity, there are instances where the interactants introduce issues that seem completely different from, although not unrelated to

HIV/AIDS and ARV. These bring a less predictable element to the consultation and give it features more typically expected in a conversation. For example, there are instances where some of the doctors enquire about their patients' employment history and plans to get a job (e.g. *line 123, Extract 09)*, plans for the Easter holiday (e.g. *Consultation 8*). It may seem random, but in fact may indicate forward planning in which the patient has to be engaged. Although it is important to distinguish features typical of different regularly used genres, HIV/AIDS consultation is conceptualised as a sub-type of consultations in the category medical consultations, and by extension, in medical discourse. This underscores the structured nature of different genres and how they are related. The CA, DA and genre theories jointly assist in clarifying the structure of HIV/AIDS ELF consultations investigated in this study. The data confirms many of the perspectives on ELF (see *section 2.3*) as a dynamic medium of communication, even if it is constantly in a state of flux, adjusting linguistic forms and communicative strategies to the setting, the purpose and the socio-cultural background of the interactants who are using it.

6.3 Summary of findings of the study

The findings of the study are presented below in response to the individual research questions, hypotheses and objectives that motivated the study and are stated in Chapter 1 (see *section 1.3*).

6.3.1 The linguistic and discursive features that characterise HIV/AIDS ELF consultations

The study identified a number of linguistic and discursive features that characterise HIV/AIDS consultations in clinics where English is used as lingua franca. My analyses illustrate how turns are organised, which sequences regularly occur and how they are structured, which repair strategies predominate, and how local metaphor and analogy feature in these discourses. Also, the occurrence of indigenisation, non-standard syntax, lexical borrowing and language-switching is identified and illustrated.

6.3.1.1 Turn-taking pattern and turn duration

Like any other interaction that involves more than one participant, the consultations reveal the use of turns. The consultations generally observe the two turn-taking principles that have been identified in CA, that is, the 'one speaker speaks at a time' and the 'recurrence of speakership' principles (Sacks et al. 1974). There are of course a few instances of simultaneous speech (*Extract 02, section 5.2.1*). Turn time for each interactant is determined by the particular phase of the

consultation, the topic under discussion and who the speaker is. For example, during the history-taking phase, the patient's turns are longer as the patient is providing information. During the diagnostic and prescription phases the doctor's turns are longer. It is evident that the doctors initiate more turns than the patients, therefore assuming the role of the dominant participants in the interaction and often exerting more control on the progress of the consultations. The turn-taking patterns and turn duration are not ostensibly influenced by the fact that the interactants were speaking ELF. However, a comparative study was not undertaken, thus this could not be confirmed. Due to the fact that they are more familiar with the institutional setting, doctors more often initiate turns and claim the floor for longer turns than patients do. Their knowledgeability regarding medical aspects of HIV/AIDS and perhaps in some instances also their fluency in English, contribute to this kind of participation in turn-taking.

6.3.1.2 Sequences

The sequences in the HIV/AIDS consultations reflect the different kinds of activities in which the interactants are involved in each phase of the consultation. The sequences change as the consultation unfolds and generally follow a particular pattern, beginning with the greetings, the history-taking phase, the examination and diagnostic phase, the prescription and instruction phase, and the closing phase. The different phases are marked by the introduction of new topics. The interactants can and do discuss several topics as the sequences change.

The consultation usually begins with greeting sequences typically characterised by the question/response adjacency pairs, composed of shorter turns, as opposed to the longer and more elaborate turns of the patient in the history-taking phases or those of the doctor in the prescription and instruction-giving phases. Topic change is often initiated by the doctor (*section 5.4.1*). However, some patients do introduce new topics either of their own accord or when prompted by the doctor; e.g. more assertive patients initiate topic changes to bring a particular health concern that has not yet been discussed to the knowledge of the doctor, as was illustrated in lines 54-60, Consultation 4 (*section 5.4.1*). Thus, when it occurs in this context where patients are predominantly African, this is significant. This is because the African patients who form a majority of the participants in this research are gradually gaining some confidence in expressing their views. This reveals a shift from the Apartheid era during which they were reportedly deprived of their initiative by the laws which pervaded communication in all aspects (Ellis 2004: 44). Growing assertiveness would be indicative of patients' growing awareness of their rights to quality health care and their responsibility to take charge of their own health and wellbeing. This reveals a

development in communicative style that would need further attention in research. Like in all other medical and institutional discourses, the sequence structure in the HIV/AIDS consultations in the present study generally consists of the three-part sequence structure characterised by a question, answer and response referred to as reactive (R) as well as several speaking opportunities for each interactant. The results indicate that whereas the patient uses his/her R to acknowledge the doctor's response, the doctor uses his for the same purpose as well as to end the patient's turn. The doctor also uses the R to introduce a new topic as shown in Figure 2 (*section 5.2.2*)

6.3.1.3 Repair strategies

The results show that the use of repair strategies in these discourses is of a very specific kind. Due to the 'let it pass principle' and the co-operative and collaborative nature of ELF interactions there are few instances of repair. There is evidence of self-repair as evident in doctor-initiated self-repair (*Extract 11*), patient-self repair (*Extract 15*) and other-repair, shown patient-initiated doctor repair (*Extract 13, 14*) doctor-initiated patient repair (*Extract 12*). There is however interesting evidence of repairs where either the doctor or the patient needs to ascertain that they have understood each other well in terms of e.g. recognition of symptoms or adherence to the medication protocol. Thus repairs are largely introduced to ensure a reasonable degree of mutual understanding and progress of the interaction. However, the results show that there is more self-initiated than other-initiated repair strategies used because the interactants are aware of their limitations and work harder to offset misunderstanding while expecting their interlocutors to do same. There is also evidence of joint negotiation of meaning which highlights the collaborative nature of ELF (see *Extract 10*). It is important to note that the type of repair present here can be attributable to interactants' proficiencies in ELF but also to their familiarity with the topic under discussion.

6.3.1.4 Use of local metaphor and analogy

The results indicate that the interactants, in particular the doctors use local metaphors and analogy relevant to the South African milieu to make some of the HIV/AIDS technical terminologies and related concepts more accessible. For example, (*Extracts 17* & *18, section 5.3.1.2*) some of the doctors likened the red blood cells reflected in the CD4 count to "The good people in the township" and the viruses reflected in the viral load figures to the "skollies". Some doctors used metaphors related to rugby and soccer teams to describe the effect of the combination treatment of the ARVs. This use of metaphor and analogy is enforced by a lot of detailed explanation which runs through

all the consultations to describe the medication and the way they work, as well as other HIV-related concepts such as CD4 count and viral load.

6.3.1.5 Indigenisation, lexical borrowing and non-standard syntax

In discussing HIV and the opportunistic infections, the interactants often use indigenised lexical and linguistic forms. These forms reflect the fluid nature of ELF, as is typically found and widely discussed in work on "New Englishes" (Kachru 1990, 1997). The participants display their embeddedness in the setting through the mixing and transfer of linguistic features from their L1. The regular use of particles such as Afrikaans '*neh'* and *'yho' and 'mos'* (*section 5.3.2.3*) highlights the linguistic practices of both the Afrikaans and isiXhosa L1 speakers, marking these discourses as particularly South African. The results further indicate that the interactants use relatively simple grammatical forms and vocabulary (*section 5.3.2.1*) to negotiate and achieve mutual understanding.

6.3.1.6 Code-switching

Code-switching is one of the discursive features that typify all communication in multilingual contexts. This is also used prominently during the HIV/AIDS consultations. From the evidence in the data it can be inferred from what the interactants say in English that code-switching is used for intra-group or cultural solidarity (*Extract 20*), to identify an addressee (*Extract 22*) and even to exclude or include somebody from the interaction (*Extract 21*). The transcriptions have the translations of the text which the interactants produced during code-switching put alongside the original L1 version where they occur only after the analyses had been done. Thus, this translation is for the interest of the reader and not to influence the researcher's analysis because the researcher does not understand the L1s. Also the researcher's intention was to find out how the interactants made sense of their conversation despite the code-switching. So translating the code-switched text to help with the analysis would defeat that goal. This is why the conclusions arrived at on code-switching are not entirely reliable because they are based on inference and guess work by the researcher. The results attest to the fact that lingua francas, ELF inclusive do convey emotional ties and the cultural identity (*Extract 20*) of their users, like in the case of the use of code-switching where interactants identified with each other and were excited that they could each speak Sotho. As hypothesised some of the features identified above, which characterise the HIV/AIDS consultations present many parallels with general features of consultations in other chronic illnesses such as cancer (see Street 1991; Hydén & Bülow 2006). As evident in this study, some of these features

such as indigenisation, non-standard syntax, lexical borrowing and code-switching are evident in ELF usage.

6.3.2. Features that signify interactants' level of proficiency, familiarity and awareness

The study shows that when interactants possess a reasonable level of proficiency and are comfortable with the communicative situation, they participate more effectively and confidently in the HIV-consultation as in most of the consultation as seen in the examples of detailed explanation and the use of analogy (see *sections 5.3.1.1* & *5.3.1.2*). Formal linguistic features such as the syntax and vocabulary are widely taken as indicators of the level of proficiency of a speaker. The use of non-standard and sophisticated vocabulary would indicate a high level of proficiency in English and vice versa. Viewed from this standpoint therefore, the proficiency levels of the patients in the present study are generally lower than that of the doctors. The use of semantic aids such as metaphors, analogy and detailed description by the doctors signify that they are aware of the communicative context and fragility of the HIV/AIDS consultation using ELF in the particular clinics. Doctors demonstrate their sensitivity to the fragile nature of the consultation by toning down their language through paraphrase (see *Extract 1*4) and establishing a level of simplicity (*section 5.3.1.2*) and camaraderie (see *Consultations 3, 4, 6* & *8*) which allows the patients to connect with them in a way that facilitates communication and ensures understanding.

The patients too, while they often come across as passive partners in such interactions, in this study ask questions about things they do not understand. This is evident in their active engagement in the consultation and sometimes in their attempts at initiating repair when misunderstanding occurs (see *section 5.2.3.3*). Some patients are even becoming confident enough to introduce topics, ask questions and discuss social issues that are not health-related (see *sections 5.4.1* & *5.4.2; Consultations 3* & *11, 14*) during the consultations. Although there are a few examples of patients who are still reluctant to ask questions even when prompted (see *line 32, Consultation 13*) this study challenges the traditional portrayal of patients as passive partners in the consultation (Ohtaki et al. 2003; Street, Krupat, Bell, Kravitz & Haidet 2003; Potter & McKinlay 2005).

The patients' willingness to talk openly and proffer any information that the doctors request emphasises the interview and yet conversation format of the interaction and the genre which influences topic introduction (see *section 5.4.1*). But this interview-conversation format, diminishes in a very significant way the patient insecurities and fragility that the researcher expected (see *section 1.3.2*) would characterise the HIV/AIDS consultation and makes the consultation friendly

(see *Consultations 4* & *8*). So although the consultation is not balanced, the prediction that the interaction of the patient will be prone to longer silences and shorter conversational turns and a display of insecurity can be challenged (see *Consultations 3, 11, 14*). The fact that the patients have come to the clinic is indicative of the concern for their health. This is displayed in the discussion of their symptoms and concerns and their willingness to get treatment (see *section 5.4.3* & *Extract 26*).

The results of the study further show that even though the doctors have higher levels of proficiency in ELF than the patients, both participants have appropriated ELF and are comfortable enough to use it to express their views and desires with regard to something as serious as HIV/AIDS. The doctor's control of the interaction is indicative of their knowledgeability in HIV/AIDS-related issues and their familiarity with the context and can also be attributable to the institutional set-up at the clinic.

6.3.3. Identification and resolution of misunderstanding

The results of this study show that there are fewer instances of misunderstanding than would be expected among speakers of mutually unintelligible L1s, and that those that do occur are typically marked by questions or a display of confusion by one of the participants or the initiation of some kind of repair (*section 5.2.3*). The study has evidence of instances where the interactants anticipate a trouble spot for misunderstanding and make an effort to manage it before it occurs by initiating self-repair (see *Extract 11, section 5.2.3.2*). A few instances are evident where interactants resolve explicit misunderstanding (*section 5.2.3.1*) after it has occurred by making an overt request for repair or introducing a confirmation check. There are instances of self-repair and other-initiated repair by both doctor and patient in the consultation, which is portrayed in the form of questions or the abandonment of troublesome lexical items. It is also seen in the management of certain topics that are either echoed and recycled or paraphrased (*Extract 23, section 5.4.1*) that such strategies can offset misunderstanding.

6.3.4. Typical linguistic and discursive ELF features present in the HIV/AIDS consultations

Despite the phenomena that uniquely mark HIV/AIDS consultations, there are certain linguistic and discursive features that are typical of ELF interactions more generally. These include the use of simple, less sophisticated grammatical vocabulary items, the use of collaborative negotiation of meaning (*section 5.2.3.1*), detailed explanation (*section 5.3.1.1*), indigenisation and code-switching (*section 5.3.2.2*). In this research, the interactants use limitedly complex grammatical forms and

generally co-operate in their efforts to negotiate and achieve mutual understanding. In this way, they tend to overlook the conventional ungrammaticality in structures such as "they did took your blood hey?" (see *section 5.3.2.1*) and jointly work harder to offset any misunderstanding that could result from such language use. The interactants often do this by asking a question of some sort or abandoning a troublesome lexical item as seen in the management of some topics such as when the patient and doctor both decide to discontinue trying to get a name for the animal from whose skin the patient's belt was made (see *section 5.4.1* & *Extract 10*). This communicative behaviour is typical of ELF interactions and was first referred to in an earlier study as the 'let it pass principle' (Firth 1996). As predicted, the use of these features is an indication that ELF fulfils communicative functions that are comparable to the ones used in any context where a lingua franca is used, such as the facilitating function in communication between people in a multi-lingual context who do not share a common language.

6.4 Impact of study

This research focused on communicative and discursive aspects of the use of ELF in a multilingual situation in medical context. Its interest was in how the transmission of information between doctors and patients occurs during HIV/AIDS consultations. In carrying out the study, the researcher has recognised features and strategies suggested in the analytic approaches that were appropriated as these are used by doctors and patients. For example, the negotiation of meaning, the organisational structure of the consultation and the manner in which participants signal and resolve any misunderstanding given their varied levels of proficiency in English. These were found to match structures and strategies identified by other researchers in ELF (see House 2003; Meierkord 2006b; Mauranen 2006). In particular, this study has used data where health workers, such as doctors and nurses, and patients use ELF as a tool to negotiate and discuss important health issues and establish personal relationships while at the same time respecting the established social order in an institutional context such as that in the clinic. The study has further enabled the researcher to identify linguistic and communicative features used by doctors and patients to facilitate communication during consultation and ensure mutual understanding on issues related to a life threatening disease such as HIV/AIDS. The study has contributed to HIV/AIDS communication research by providing insight into doctor-patient interactions in a multilingual clinic from a data-driven analysis of life situations.

Although the present study was aimed at investigating language issues, it has uncovered communicative features that can inform policy and treatment protocol in HIV/AIDS care. The study

will hopefully open a discussion, particularly amongst doctors and other care givers, as to particular linguistic practices that either inhibit or enhance their communication with patients whose linguistic and cultural identities differ from their own. It could also help in alerting patients, health workers and policy makers to ways in which patients can be more actively involved in discussing their health matters during consultations in order to have some ownership and control of their medical outcomes. Although not specifically investigated, the presence of more female patients at the clinics could be an indication that women are more forthcoming and open about their HIV status than men and are more willing and ready to take part in this kind of research than men are.

6.5 Challenges faced during research

One of the main challenges that the present study posed was that although the focus was a linguistic one, it was difficult to analyse the data purely from the CA, DA and genre perspectives because as mentioned before, medical consultations as part of medical discourses engender different aspects of the human experience that require the discussion of other theories albeit briefly. Consequently, the discussions unavoidably touched on aspects of critical discourse analyses (CDA) as mentioned in section 5.2.1 to highlight some evidence of the power dynamic in the HIV/AIDS consultations and on the flouting of conversational maxims in the speech act theory in pragmatics. The discussion reveals how interactants apply conversational rules and use language to perform their different tasks and how this affects the conversational rules they follow (*section 5.2.2.5*).

Since the research focused on doctor-patient consultation in HIV/AIDS clinics, which is a very sensitive context, the choice of method for data collection was limited. Ethical considerations prohibited intrusive methods of recording, thus audio-recording was the only method used.

The participants in the study (doctors and patients) were required not to share a common L1 and to use English for consultation. The researcher or hospital staff did not in any way influence the participants' language choice. However, some who agreed and took part in the study proved to be more multilingual than was anticipated. For example, some shared more languages than the L2-English used in the consultations. This introduced more variables and made it difficult to have complete control over their language choice during the consultation. It is not certain whether the outcome of their consultations would have been any different had they used a shared L1 (such as Afrikaans) instead of ELF. In addition, the fact that the participants were required not to share a common L1 and to use English in the consultation, considerably limited the number of people eligible for selection.

Another challenge encountered in the study was that of trying to achieve gender equity in the selection of participants, even though this was not selected as a critical variable in the study. There were fewer male patients than female ones who consented to take part in the study. Of the few, some later withdrew as was provided for in the consent form. From this perspective, the results are unavoidably gender biased. This could be read as an indicator to policy makers that the male folk do not frequent the HIV/AIDS clinics as much as their female counterparts do and that specific communication strategies need to be put in place to target them.

The researcher originally intended to record between thirty and forty consultations in about eight weeks. But due to the protracted procedure to obtain the ethical clearance and due consent, as well as to logistical and financial constraints, the researcher obtained slightly less, i.e. 29 recordings within a period of about seven weeks. Only 19 of these recordings were viable for analysis because some participants later decided to withdraw their consent to be part of the study. However, this did not affect the analysis in a negative way since the investigation was intended to be qualitative from the outset, and the findings are based on the consultations that actually took place, irrespective of the number.

6.6 Recommendations for further research

One of my recommendations is that (with due ethical considerations) the use of non-verbal data of doctor-patient interactions in HIV/AIDS consultations be investigated through the use of video-recordings. This could check information gotten from such data, and may give a clearer or deeper understanding of the particular kind of interaction. Such follow-up work would acknowledge that doctor-patient communication, like all other interactions, is both verbal and non-verbal. Sometimes in face-to-face interactions people's body language or gaze may indicate the opposite of what they say verbally and may provoke a different response. However, the presence of a video cameraman during the consultation will be intrusive and could invoke the observer's paradox, thus presenting data that is not necessarily naturally occurring. The situation can be remedied with the use of a digital camera that has an automatic recording function in order to avoid the intrusion of a camera-person.

It would be interesting to conduct a follow-up study which includes the use of data collected through the use of audio-recordings, formal interviews and questionnaires to get insight into participants' opinion on how ELF instead of their L1 impacts on the quality of their consultation.

Also, this study could serve as a basis for similar studies in other multilingual communities that face similar communication challenges.

The fact that more female patients consented to participate in the study could be an indication that women are more forthcoming and open about their HIV status than men. Researchers in HIV/AIDS studies should first confirm this hypothesis and, if proven, should develop strategies to get the male patients more involved.

It would be interesting to conduct a similar study in which the consultation is carried out in other combinations of languages, such as among L1 speakers of Afrikaans, L1 speakers of English, L1 speakers of isiXhosa, or combinations of any of these as L1s and L2s. Comparative studies may assist in distinguishing those communicative features that are specifically ELF-determined, or otherwise typical of L2-interaction (and not only when the L2 is English).

Also, the patient's world view is often different from the doctor's due to the fact that the patient is usually less knowledgeable in health matters than the doctor, whose training and extensive knowledge is a critical element in the interaction. It would be interesting to investigate to what extent the different world views impact on the consultation, also in ones in which doctor and patient share the same L1.

Considering the context-specific nature of some of the lingua franca interactions such as those in this study, it would be interesting to explore the benefits of pictorial aids to explanations of particular concepts, by incorporating other concepts such as *'townships'* and *'skollies'*.

Finally, I would suggest further investigation to find out whether there is any difference in the ease with which patients understand information communicated during HIV/AIDS consultations conducted in ELF and those conducted with the aid of an interpreter.

BIBLIOGRAPHY

Ackermann, M. D. (2006). From existence to tenacious endurance. Stigma, HIV/AIDS and a feminist theology of praxis. In: Apawo, P. I. (Ed.) *African women, religion and health. Essays in honor of Mercy Ambe Ewudziwa Oduyoye* (pp. 221-241). Pietermaritzburg: Cluster Publications.

Adams, J. N. (2003). *Bilingualism and the Latin language*. Cambridge: Cambridge University Press.

Adegbite, W. and Odebunmi, A. (2006). Discourse tact in doctor-patient interactions in English: An analysis of diagnosis in medical communication in Nigeria. *Nordic Journal of African Studies* 15**:** 499-519.

Ainsworth-Vaughn, N. (1998). *Claiming power in doctor-patient talk*. Oxford, UK: Oxford University Press.

Ainsworth-Vaughn, N. (2003). The discourse of medical encounters. In: Schiffrin, D., Tannen, D. and Hamilton, H. E. (Eds.). *The handbook of discourse analysis* (pp. 453-469). Oxford: Blackwell Publishers

Akaah, I. P. and Riordan, E. A. (1989). Judgments of marketing professionals about ethical issues in marketing research: A replication and extension. *Journal of Marketing Research* 26(1): 112-120.

Alasuutari, P. (1995). *Researching culture: Qualitative method and cultural studies*. London: Sage.

Ammerman, S., Perrili, E., Alder, N. and Irwin, C. (1992). Do adolescents understand what physicians say about sexuality and health? *Clinical Paediatrics* 3**:** 590-595.

Andersen, P. A. (1999). *Nonverbal communication: Forms and functions*. New York: Mayfield.

Anthonissen, C and Meyer, B. (2008). Doctor-patient communication in a South African HIV/AIDS day clinic. Paper presented at the 5th International communication. Medicine and Ethics (COMET) Conference. Lugano, Switzerland.

Anthonissen, C. (2010). Managing linguistic diversity in a South African HIV/AIDS day clinic. In: Meyer, B. and Apfelbaum, B. (Eds.). *Multilingualism at work. From policies to practices in public, medical and business settings* (pp. 107-139). Amsterdam: John Benjamins.

Applegate, M. (2011). Five types of genres in writing. Available at: http://www.ehow.com/info_12148959_five-types-genres-writing.html. Accessed on 21/10/2011.

Atkinson, J. M. and Heritage, J. (Eds.). (1984). *Structures of social action: Studies in conversation analysis*. London: Oxford University Press.

Avis, M. (2005). Is there an epistemology for qualitative research? In: Holloway, I. (Ed.) *Qualitative research in health care.* (pp. 3-16). New York: Open University Press.

Bae, J. H. (2002). Discourse strategies solving trouble in German lingua franca communication. In: Knapp, K. and Meierkord, C. (Eds.) *Lingua Franca communication.* Frankfurt Am Main: Peter Lang.

Bamgbose, A. and Banjo, A. (Eds.). (1995). *New Englishes: A West African perspective*. Ibadan: The British Council.

Baraldi, C. and Gavioli, L. (2010). Interpreter-mediated interaction as a way to promote multilingualism. In: Meyer, B. and Apfelbaum, B. (Eds.). *Multilingualism at work: From policies to practices in public, medical and business settings.* (pp. 141-162). Amsterdam: John Benjamins.

Barotchi, M. (1998). Lingua franca. In Mey, J. L. (Ed.). *Concise Encyclopedia of Pragmatics*. (pp. 505) Oxford: British Library in Cataloguing in Publication Data.

Barrier, P. A., LI, J. T-C. and Norman, J. J. (2003). Two words to improve Physician-Communication: What else? *Mayo Clinic Proceeding* 78**:** 211-214.

Beisecker, A. E. (1990). Patient power in doctor-patient communication: What do we know? *Health communication* 2**:** 105-122.

Bensing, J. M. (1991). Doctor-patient communication and the quality of care. *Social Science and Medicine* 32*:* 1301-1310.

Bhatia, V. K. (1993). *Analysing genre: Language use in professional settings*. London, New York: Longman.

Bhatia, V. K. (2004). *Worlds of written discourse: A genre-based view.* York Road, London: Continuum.

Bhatt, R. (2005). Expert discourses, local practices, and hybridity: The case of Indian Englishes. In Canagarajah, A. S. (Ed.) *Reclaiming the local in language policy and practice.* (pp. 25-63). Mahwah, NJ: Lawrence Erlbaum Associates.

Boxer, D. (1992). Speech behaviour and social distance: exploring gender issues. *Journal of Pragmatics* 18: 103-125.

Boxer, D. (2002). *Applying Sociolinguistics: Domains and face-to-face interaction*. Amsterdam, Philadelphia: John Benjamins.

Brashers, D. E., Goldsmith, D. J. and Hseih, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research* 28**:** 258-271.

Bremer, K. (1996). Causes of understanding problems. In: Bremer, K., Roberts, C., Vasseur, M-T., Simonot, M. and Broeder, P. (Eds.). *Achieving understanding: Discourse in intercultural encounters* (pp. 37-64). London: Longman.

Brown, G. and Yule, G. (1986). *Discourse Analysis*. Cambridge: Cambridge University.

Brown, K., Anderson, A. H., Bauer, L., Margie, B., Graeme, H. and Jim, M. (2006). *Encyclopedia of language and Linguistics*. Oxford: Elsevier Ltd.

Bubenik, V. (1989). *Hellenistic and Roman Greece as a sociolinguistic area.* Amsterdam: John Benjamins.

Bührig, K. and Ten Thije, J. D. (2006). *Beyond misunderstanding: Linguistic analysis of intercultural communication*. Amsterdam: John Benjamins.

Buus, N. (2005). Nursing scholars appropriating new methods: The use of discourse analysis in scholarly nursing journals1996-2003. *Nursing Enquiry* 12**:** 27-33.

Cameron, D. (1992). 'Respect please!': Investigating race, power and language. In: Cameron, D., Fraser, P., Harvey, M. B., Rampton, H. and Richardson, K. (Eds.), *Researching language issues of power method* (pp. 113-138). London: Routledge.

Cameron, E. (2005). *Witness to AIDS.* Cape Town. Tafelberg Press.

Cameron, E. (2007). Discussion: Normalising testing-normalising AIDS. *Theoria: Journal of Social and Political Theory* 54: 99-108.

Campbell, C., Nair, Y. and Maimane, S. (2006). AIDS stigma, sexual moralities and the policing of women and youth in South Africa. *Feminist Review* 82**:** 132-138.

Campbell, C., Nair, Y., Maimane, S. and Nicholson, J. (2007). 'Dying twice': A multi-level model of roots of AIDS stigma in two South African communities. *Journal of Health Psychology* 12**:** 403-416.

Canagarajah, A. S. (2006). Negotiating the local in English as a lingua franca. *Annual Review of Applied linguistics***:** 26: 197-218.

Chomsky, N. (1965). *Aspects of the theory of syntax*. Cambridge, MA: MIT Press.

Cichocki, M. (2007). What is a CD4 count and why is it important? Available at: *http://aids.about.com/z/js/o.htm?k=definitions*. Accessed on 28/8/2011.

Coleman, T. (2000). Using video-recorded consultations for research in primary care: Advantages and limitations. *Family Practice* 17: 422-427.

Colvin, J. C. and Robins, S. (2009). Social movements and HIV/AIDS in South Africa. In: Rohleder, P., Swartz, L. and Kalichman, C. S. (Eds.). *HIV/AIDS in South Africa 25 years on-Psychosocial perspectives.* (pp. 155-164). New York, London: Springer.

Cook, G. (1989). *Discourse*. Oxford: Oxford University Press.

Cordella, M. (2004). *The dynamic consultation: A discourse analytical study of doctor-patient communication*. Amsterdam: John Benjamins.

Coupland, N. and Adam, J. (1997). *Sociolinguistics: A reader and course book*. Basingstoke, Hampshire: Macmillan.

Crawford, A. (1999). 'We can't all understand the whites' language': an analysis of monolingual health services in a multilingual society. *International journal of the sociology of Language* 136: 27-46.

Crystal, D. (1997). Pidgins and Creoles. In: Crystal, D. (Ed.). *The Cambridge Encyclopedia of language* (pp. 334-351) (Second Edition). Cambridge: Cambridge University Press.

Crystal, D. (2001). The future of Englishes. In: Burns, A. and Coffin, C. (Eds.) *Analyzing English in a global context: a reader*. (pp. 53-65). London, New York: Routledge.

Crystal, D. (2003). *English as a global language*. Cambridge: Cambridge University Press.

Deacon, H., Inez, S. and Prosalendis, S. (2005).*Understanding HIV/AIDS stigma: A theoretical and methodological analysis*. Cape Town: Human Science Research Council Press.

Deacon, H. and Inez, S. (2007). *HIV/AIDS, stigma and children: A literature review*. Cape Town: Human Science Research Council Press.

De Klerk, V. (Ed.) (1996). *Varieties of English around the world: Focus on South Africa. Amsterdam*: John Benjamins.

De Klerk, V. (1999). Black South African English: Where to from here? *World Englishes* 18(3): 311-324.

De Swaan, A. (2001). *Words of the world*. Oxford, U.K.: Polity.

Deumert, A. (2010). It would be nice if they could give us more language-Serving South Africa's multilingual patient base. *Social Science and Medicine* 71: 53-61.

Dewalt, K . M. and Dewalt, B. R. (2002). *Participant observation: a guide for fieldworkers*. Walnut Creek, CA: Alta Mira Press.

Dewey, M. (2007a). English as lingua franca and globalisation: An interconnected perspective. *International Journal of Applied Linguistics* 17: 332-354.

Dewey, M. (2007b). *English as a lingua franca: an empirical study of innovation in lexis and grammar*. London: King's College.

Dube, W. M. (2006). Adinkra! Four hearts joined together. On becoming healing-teachers of African indigenous religion(s) in HIV/AIDS. In: Phiri, A. I. and Nadar, S. (Eds.). *African women, religion and health. Essays in honor of Mercy Amba Ewudziwa Oduyoye*. (pp. 131-151). Pietermaritzburg: Cluster Publications. Maryknoll, New York: Orbis Books.

Edwards, C., Staniszewska, S. and Crichton, N. (2004). Investigation of the ways in which patients' reports of their satisfaction are with health care are constructed. *Sociology of Health and Illness* 26: 159-183.

Ellis, C. (1999). *Learning language and culture in the medical consultation*. Parktown North, South Africa: Sue McGuinness Communications.

Ellis, C. (2004). *Communicating with the African patient*. Scottsville: University of KwaZulu-Natal Press.

Ellison, G., Parker, M. and Campbell, C. (Eds.) (2003). *Learning from HIV and AIDS*. Cambridge: Cambridge University Press.

Elwyn, G., Edwards, A. and Kinnersley, P. (1999). Shared decision making: the neglected second half of the consultation. *British Journal of General Practice* 49: 477-482.

Fairclough, N. (2001). *Language and power*. London: Longman.

Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. New York: Routledge.

Firth, A. (1990). Lingua franca negotiations: towards an interactional approach. *World Englishes* 9**:** 269-280.

Firth, A. (1996). The discursive accomplishment of normalcy. On 'lingua franca' English and conversation analysis". *Journal of Pragmatics* 26: 237-259.

Fiscella, K., Franks, S P., Clancy, C. M. and Gold, M. R. (2000). Inequality in quality: Addressing socio-economic, racial and ethnic disparities in health care. *Journal of the American Medical Association* 283**:** 2579-2584.

Fishman, A. J. (1971). *Sociolinguistics.* Rowley, Massachusetts: Newbury House Publishers.

Fishman, J. A., Cooper, R. L. and Conrad, A. W. (Eds.) (1977). *The spread of English: The sociology of English as an Additional Language*. Rowley, Mass: Newbury House Publishers.

Foley, A., J. (2006). English as lingua franca: Singapore. *International Journal of Sociology of Language* 177**:** 51-65.

Ford, C. E., Fox, A. B. and Thompson, A. S. (2002). *Oxford studies in sociolinguistics: The language of turn and sequence*. New York: Oxford University Press, Inc.

Forster, P. G. (1982). *The Esperanto Movement*. The Hague: Mouton.

Foucault, M. (1972). *The archaeology of knowledge*. Translated by AM. Sheridan Smith. London: Tarvistock

Foucault, M. (1988). *Technologies of the self. A seminar with Michel Foucault.* London. Tarvistock.

František, D. (1997). The present day situation of Czech. *International Journal of Sociology of Language* 162: 9-18.

František, D. (2000). People, nations and languages in contact. The drifting of Czech in the present-day flood of English. *Journal of Asian Pacific Communication* 10**:** 228-238.

Frow, J. (1980). Discourse genre. *The Journal of Literary Semantics* 9: 73-79.

Frow, J. (2006). *Genre*. New York: Routledge.

Garcia, O. and Otheguy, R. (Eds.) (1989). *English across cultures cultures across English: A reader in cross-cultural communication.* New York: Mouton de Gruyter.

Gee, J. P (2008). *Social linguistics and literacies: Ideology in discourses*. New York: Routledge.

Gill, S. K. (1999). Standards and emerging linguistic realities in the Malaysian workplace. *World Englishes* 181**:** 215-23.

Graddol, D. (1997). *The future of English*. London: British Council.

Grice, H. P. (1975). Logic and conversation. In: Cole, P. and Morgan, J. L. (Eds.) *Syntax and semantics 3: Speech Acts.* (pp. 41-58) New York: Academic Press.

Gumperz, J. J. (1982). Contextualisation conventions. In: Gumperz, J. J. (Ed.) *Discourse Strategies.* Cambridge: Cambridge University Press.

Gxilishe, D. S. (1992). Conversational code-switching. *South African Journal of African Languages* 12(3): 93-101.

Hall, S. (1997). The local and the global: Globalisation and ethnicity. In: King, A. D. (Ed.) *Culture, globalisation, and the world system* (pp. 19-40). Minneapolis, MN: University of Minnesota Press.

Halmari, H. and Virtanen, T. (2005). *Persuasion across genres.* Amsterdam: John Benjamins.

Heath, C. (1992). The delivery and reception of diagnosis in the general practice consultation. In: Drew, P. and Heritage, J. (Eds.). *Talk at work.* Cambridge: Cambridge University Press.

Herdt, G. and Lindenbaum, S. (Eds.) (1992). *The time of AIDS*. Newbury Park: Sage Publications.

Heritage, J. and Maynard, D. W. (Eds.) (2006). *Communication in medical care: Interaction between primary care physicians and patients*. Cambridge: Cambridge University Press.

Holloway, I. (Ed.) (2005). *Qualitative research in health care*. New York: Open University Press.

Holloway, I., and Todres, L. (2005). The status of method: Flexibility, consistency and coherence. In: Holloway, I. (Ed.). *Qualitative research in health care* (pp. 90-103) New York: Open University Press.

House, J. (1999). Misunderstanding in intercultural communication: Interactions in English as a lingua franca and the myth of mutual intelligibility. In: Gnutmann, C. (Ed.) *Teaching and Learning English as a global language. Native and non-native perspectives.* (pp. 73-93). Tübingen: Stauffenburg.

House, J. (2002). Developing pragmatic fluency in English as a lingua franca. In: Meierkord, K. K. A. C. (Ed.) *Lingua Franca Communication.* (pp. 245-267). Frankfurt Am Main: Lang.

House, J. (2003). English as a lingua franca: A threat to multilingualism? *Journal of Sociolinguistics* 7**:** 556-578.

House, J. and Rehbein, J. (2004). *Multilingual communication*. Amsterdam: John Benjamins.

Hüttner, J., Smit, U. and Mehlmauer-Larcher, B. (2009). ESP teacher education at the interface of theory and practice: Introducing a model of mediated corpus-based genre analysis. *System* 37: 99-109.

Hydén, L. C. and Bülow, P. H. (2006). Medical discourse, illness narratives. In: Brown, K., Anderson, A. H., Bauer, H., Berns, M., Hirst, G. and Miller, J. (Eds.). *Encyclopedia of Language and Linguistics* (pp. 697-703) (Second Edition). Oxford, UK: Elsevier Ltd.

Hymes, D. (1972). *Language in society*. Cambridge: Cambridge University Press.

Jenkins, J. (2002). A sociolinguistically based, empirically researched pronunciation syllabus for English as an international language. *Applied Linguistics* 23: 83-103.

Jenkins, J. (2006). Current perspectives on the teaching of world Englishes and English as a lingua franca. *TESOL Quarterly* 40: 157-181.

Johnson, R. L., Roter, D., Powe, N. R. and Cooper, L. A. (2004). Patient race / ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health* 94: 2084-2090.

Kachru, B. (1983). Models for non-native Englishes. In: Kachru, B. (Ed.). *The other tongue: English across cultures.* (pp. 31-57). Oxford: Pergamon.

Kachru, B. (1986). ESP and non-native varieties of English: Toward a shift in paradigm. *Studies in the Linguistic Sciences* 19: 127-152.

Kachru, B. (1990). *The alchemy of English: The spread, functions and models of non-native Englishes.* Urbana: University of Illinois.

Kachru, B. (1992). *The other tongue*. Urbana and Chicago: University of Illinois Press.

Kachru, B. (1997). World Englishes and English-using communities. *Annual review of Applied Linguistics 17: 66-90.*

Kalichman, C., Leichness, S., Cain, C. S., Jooste, D., Toefy, S., Cherry, Y. C. and Kagee, A. (2005). Development of a brief scale to measure AIDS-related stigma in South Africa. *AIDS and Behaviour* 9: 135-143.

Kaschula, H. R. and Anthonissen, A. C. (1995). *Communication across cultures in South Africa*. *Toward a critical language awareness*. Hodder and Stoughton: Johannesburg.

Klimpfinger, T. (2007). Mind you, sometimes you have to mix: The role of code-switching in English as a lingua franca. *Vienna English Working Papers.*

Labov, W. (1972). *Sociolinguistic patterns*. Philadelphia, Pennsylvania: University of Pennsylvania Press.

Lanham, L. W. (1996). A history of English in South Africa. In: De Klerk, V. (Ed.). *Focus on South Africa*. Philadelphia: John Benjamins.

Lappalainen, S. (2001). English as lingua franca. Towards fluent communication. (MA Thesis). University of Turku: Turku.

Latkin, C. A., Hua, W. and Davey, M. A. (2004). Factors associated with peer HIV prevention outreach in drug-using communities. *AIDS Education Prevention* 16(6): 499-508.

Lerner, H. G. (2004). *Conversation analysis: Studies from the first generation*. Amsterdam: John Benjamins.

Lesznyák, A. (2002). From chaos to the smallest common denominator. Topic management in English lingua franca communication. In: Knapp, K. and Meierkord, C. *Lingua franca communication*. (pp. 163-193). Frankfurt Am Main: Lang.

Lesznyák, A. (2004). *Communication in English as an international lingua franca. An exploratory case study*. Norderstedt: Books on Demand.

Levin, M.E. (2004). Language differences as an access barrier for Xhosa speaking patients at a children's hospital in Cape Town. (MMed Thesis). University of Cape Town: Cape Town, ZA.

Levin, M.E. (2006). Different use of medical terminology and culture-specific models of disease affecting communication between Xhosa-speaking patients and English-speaking doctors at a South African paediatric teaching hospital. *South African Medical Journal* 96(10): 1080-1084.

Liddicoat, A. J. (2007). *An introduction to conversation analysis*. London: Continuum

Linell, P. (1995). Troubles with mutualities: toward a dialogical theory of misunderstanding and miscommunication. In: Markova, I., Graumann, C. F.; Foppa, K. (Eds.). *Mutualities in dialogue* (pp. 176-213). Cambridge: Cambridge University Press.

Markee, N. (2000). *Conversation analysis*. Mahwah, N.J: Erlbaum Associates Inc. Publishers.

Maurais, J. A. and Morris, A. M. (Ed.) (2003). *Languages in a globalising world.* Cambridge: Cambridge University Press.

Mauranen, A. (2003). The corpus of English as lingua franca in academic settings. *TESOL Quarterly* 37: 513-527.

Mauranen, A. (2006). Signalling and preventing misunderstanding in English as lingua franca communication. *International Journal of Sociology of Language* 177: 123-150.

Mazeland, H. (2006). Conversation analysis. In: Brown, K., Anderson, A. H., Bauer, H., Berns, M., Hirst, G. and Miller, J. (Eds.). *Encyclopedia of language and linguistics.* (Second Edition) (pp. 153-163). Oxford, U.K.: Elsevier Ltd.

Mazrui, A. (2004). English in Africa: after the Cold War. In: Edwards, J. (Ed.) *Multilingual Matters* Great Britain: Cornwell Press Ltd.

McCarthy, M. (1991). *Discourse analysis for language teachers*. Cambridge: Cambridge University Press.

McLean, D. and McCormick, K. (1996). English in South Africa 1940-1996. In: Fishman, J. A., Conrad, A. W. and Rubal-Lopez, A. (Eds.). *Post Imperial English.* (pp. 303-337). Berlin and New York: Mouton de Gruyter.

McCormick, K. (2006). Afrikaans as a lingua franca in South Africa: The politics of change. *International Journal of Sociology of Language* 177: 91-109.

McCoy, L. (2005). HIV-positive patients and the doctor-patient relationship: Perspectives from the margins. *Qualitative Health Research* 15: 791-806.

McGregor, G. (1985). Utterance interpretation and the role of the analyst. *Language and Speech* 28: 1-28.

McHoul, A. (1994). Discourse. In: Asher, R. E. and Simpson, J. M. Y. (Eds.). *Encyclopedia of language and linguistics*. Oxford: Pergamon Press Ltd.

McHoul, A. (2006). Discourse, Foucauldian approach. In: Brown, K., Anderson, A. H., Bauer, H., Berns, M., Hirst, G. and Miller, J. (Eds.). *Encyclopedia of language and linguistics* (pp. 680-686). Oxford: Pergamon Press Ltd.

McKee, N., Bertrand, J. T. and Antje, B. B. (2004). *Strategic communication in the HIV/AIDS epidemic*. London: Sage Publications.

Mead, N. and Bower, P. (2002). Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Education and Counselling* 48**:** 51-61.

Meierkord, C. (2002). 'Language stripped bare' or 'linguistic masala?' Culture in lingua franca conversation. In: Knapp, K. and Meierkord, C. (Eds.). *Lingua franca communication*. Frankfurt: Lang.

Meierkord, C. (2004). Syntactic variation in interactions across international Englishes. *English Worldwide* 25: 109-132.

Meierkord, C. (2006a). Lingua francas as Second Languages. In: Brown, K., Anderson, A. H., Bauer, H., Berns, M., Hirst, G. and Miller, J. (Eds.). *Encyclopedia of language and linguistics.* (Second Edition) (pp. 163-171). Oxford, UK: Elsevier Ltd.

Meierkord, C. (2006b). Lingua franca communication past and present. *International Journal of Sociology of Language* 177: 9-30.

Mesthrie, R. (Ed.) (2002). *Language in South Africa*. Cambridge: Cambridge University Press.

Meyer, B. and Apfelbaum, B. (Eds.) (2010). *Multilingualism at work. From policies to practices in public, medical and business settings.* Amsterdam: John Benjamins.

Michie, S., Miles, J. and Wienman, J. (2003). Patient-centredness in chronic illness: what is it and does it matter? *Patient Education and Counselling* 51: 197-206.

Mishler, G. E. (1984). *The Discourse of medicine: Dialectics of medical interviews.* Norwood, N.J: Ablex Publishing Corporation.

Moa, L. (2005). Language differences as an access barrier for Setswana speaking HIV positive women attending the wellness HIV/AIDS clinic at Rustenburg Provincial Hospital in North West of South Africa. (Honours Thesis). University of Witwatersrand: Johannesburg, ZA.

Mouton, J. (2003). *How to succeed in your Master's and Doctoral studies: A South African guide and resource book*. Pretoria: Van Schaik Publishers.

Neilson, W. A., Knott, T. A. and Carhart, P. W. (Eds.). (2009). *The Webster's New International Dictionary of the English Language*. (Second Edition). Springfield, Massacchussettes: G & C. Merriam Company.

Nixon, A., and Charmaine, P. (2007). Towards a framework for establishing rigour in a discourse analysis of midwifery professionalisation. *Nursing Inquiry* 14: 71-79.

Njweipi, D. (2000). Contrastive sociolinguistic analysis of euphemisms in Cameroonian and Nigerian English. (MA Thesis). University of Ibadan: Ibadan, Nigeria.

Oates, J., Weston, W. W. and Jordan, J. (2000). The impact of patient-centred care on outcomes. *Journal of Family Practice* 49: 796-804.

Ochs, E. (1979). Planned and unplanned discourse. In: Given, T. (Ed.). *Discourse and syntax*. (pp. 51-80). New York: Academic Press.

Ochs, E., Schegloff, E. A. and Thompson, S. A. (Eds.) (1996). *Interaction and grammar*. Cambridge, England: Cambridge University Press.

Ohtaki, S., Ohtaki, T. and Fetters, M. D. (2003). Doctor-patient communication: a comparison of the USA and Japan. *Family Practice* 20: 276-282.

Ong, L. M. L., De Haes, J. C. J. M., Hoos, A. M. and Lammes, F. B. (1995). Doctor-patient communication: A review of literature. *Social Science and Medicine* 40: 903-918.

Orr, R. D. (1996). Treating patients from other cultures. *American Family Physician* 53: 2004-2006.

Paltridge, B. (2006). *Discourse Analysis*. London: MPG Books Ltd.

Pendleton, D. and Hasler, J. (1983). *Doctor-Patient Communication*. London: Academic Press Inc.

Penn, C. (2007). Factors affecting mediated medical interviews in South Africa. *Current Allergy and Clinical Immunology* 20: 66-72.

Pennycook, A. (1994). *The cultural politics of English as an international language*. London: Longman.

Perakyla, A. (1997). Conversation analysis: A new model of research in doctor-patient communication. *Journal of Royal Society of Medicine* 90**:** 205-208.

Piqué-Angordans, J. and Posteguillo, S. (2006). Medical discourse and academic genres. In: Brown, K., Anderson, A. H., Bauer, H., Berns, M., Hirst, G. and Miller, J. (Eds.). *Encyclopedia of language and linguistics.* (Second Edition). (pp. 649-657). Oxford, U.K.: Elsevier Ltd.

Pittam, J. and Gallois, C. (2000). Malevolence, stigma, and social distance: Maximising intergroup differences in HIV/AIDS discourse. *Journal of Applied Communication Research* 28: 24-43.

Pitzl, M.-L. (2005). Non-understanding in English as a lingua franca: Examples from a business context. *Views* 14: 50-71.

Pölzl, U. and Seidlhofer B. (2006). In and on their own terms: the 'habitat factor' in English as a lingua franca interactions. *International Journal of Sociology of Language* 177: 151-176.

Post, D. M., Cegala, D. J. and Miser, W. F. (2002). The other half of the whole: Teaching patients to communicate with physicians. *Family Medicine* 34: 344-352.

Potter, S. J. and Wetherell, M. (1987). *Discourse and social psychology*. London: Sage

Potter, S. J. and Wetherell, M. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. London: Harvester Wheatsheaf.

Potter, S. J. and McKinlay, J. B. (2005). From a relationship to encounter: An examination of longitudinal and lateral dimensions in the doctor-patient relationship. *Social Science and Medicine* 61: 465-479.

Prevignano, C. and Thibault, J. P. (2003). *Discussing conversation analysis: The work of Emmanuel Schegloff*. Amsterdam: John Benjamins.

Republic of South Africa (1996). Constitution of the Republic of South Africa. The Government Gazette: Pretoria.

Richards, J. C. and Schmidt, R. (2002). *Longman dictionary of language teaching and Applied Linguistics*. (Third Edition). Harlow, UK: Longman.

Rohleder, P., Swartz, L., Kalichman, C. S. and Leichness, C. S. (Eds.) (2009*). HIV/AIDS in South Africa 25 years on-Psychosocial perspectives*. New York, London: Springer.

Roter, D. L. (1991). The Roter Method of interaction process Analysis System (RIAS) coding manual. Baltimore: School of Hygiene and Public Health, Johns Hopkins University.

Roter, D. L. and Hall, J. A. (1992). *Doctors talking with patients, patients talking with doctors*. Westport, CT: Auburn House.

Sacks, H., Schegloff, E. A. and Jefferson, G. (1974). A Simplest Systematics for the organisation of turn-taking for conversation. *Language* 50: 696-735.

Sacks, H. and Jefferson, G. (1992). *Lectures on conversation.* Oxford: Basil Blackwell.

Samarin, W. J. (1987). Lingua franca. In: Ammon, U., Dittmar, N. and Klauss, M. J. (Eds.). *Sociolinguistics: An international handbook of the science of language and society*. (Volume 1) (pp. 371-374). Berlin: Mouton de Gruyter.

Schegloff, E. A. (1987). 'Recycled turn beginnings: A precise repair mechanism in conversation's turn-taking organisation'. In: Button, G., Lee, J. R. E (Eds.) *Talk and social organisation* (pp. 70-85). Clevedon, England: Multilingual Matters.

Schegloff, E. A. (1992). Repair after next turn: the last structurally provided defence of intersubjectivity in conversation. *American Journal of Sociology* 97: 1295-1345.

Schegloff, E. A. (2001). Discourse as an Interactional achievement III: The omni-relevance of action. In: Schiffrin, D., Tannen, D. and Hamilton, H. (Eds.). *The hand book of discourse analysis* (pp. 229-249). Oxford: Blackwell Publishers Ltd.

Schiffrin, D., Tannen, D. and Hamilton, H. (Eds.) (2001). *The handbook of discourse analysis*. Oxford: Blackwell Publishers Ltd.

Schlemmer, A. and Mash, B. (2006). The effects of language barrier in a South African district hospital. *South African Medical Journal* 96 (10): 1084-1087.

Schneiderman, N., Speers, M. A. and Silva, J. M. (Eds.). (2001). *Integrating behavioural and social sciences with public health*. Washington, DC: American Psychological Association.

Schouten, B. C. and Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counselling* 64: 21-34.

Schwartz, T. (2004). Communication in Health within the South African context: Current practices employed across three levels of health care. (MA Thesis). University of Cape Town: Cape Town, ZA.

Seidlhofer, B. (2000). Mind the gap: English as a mother tongue vs. English as a lingua franca. *Vienna Working Papers* 9: 51-68.

Seidlhofer, B. (2001). Closing a conceptual gap: The case for the description of English as a lingua franca. *International Journal of Applied Linguistics* 11(2)**:** 133-158.

Seidlhofer, B. (2004). Research perspectives on English as a lingua franca. *Annual Review of Applied Linguistics* 24: 209-239.

Seidlhofer, B. (2005). "English as a lingua franca". *ELT Journal* 59: 339-341.

Sidnell, J. (2010). *Conversation analysis: An introduction.* Malden, UK: Wiley-Blackwell.

Simpson, P. W. (1998). Discourse analysis and literature. In: Mey, J. L. *Concise encyclopedia of pragmatics* (pp. 236-241). Oxford: British Library catalogue in publication data.

Singhal, A. and Everett, M. R. (2003). *Combating AIDS: Communication strategies in action.* London: Sage Publications.

Smit, U. (1996). *A new English for a new South Africa? Language attitudes, language planning and education*. Wien Braumüller.

Smit, U. (2005). Multilingualism and English: The lingua franca concept in language description and language learning pedagogy. *Symposium on Multilingualism and Communication in Diplomacy at the Diplomatic Academy*. Vienna.

Smit, U. (2010). English as a lingua franca in higher education: A longitudinal study of classroom discourse. Berlin/New York: De Gruyter Mouton.

Soul City and Khomanani (2004). *HIV and AIDS: Prevention, care and treatment*. Johannesburg: Jacana Media.

Spender, D. (1980). *Man-made language*. London: Routledge and Kegan Paul.

Statistics South Africa (2003). *Census 2001: Census in brief*. Pretoria: Statistics South Africa

Statistics South Africa (2006). *Provincial Profile: Western Cape*. Pretoria: Statistics South Africa.

Stockinger, P. (2003) *Semiotics of cultures: Culture, language and translation*. Paris, European Masters in Intercultural Communication (EEMIC).

Street, R. L. (1991). Information-giving in the medical consultations: The influence of patients' communication styles and personal characteristics. *Social Science Medicine* 32 (5)**:** 541-548.

Street, R. L. J., Krupat, E., Bell, R. A., Kravitz, R. L. and Haidet, P. (2003). Beliefs about control in physician-patient relationship: Effect on communication in medical encounters. *Journal of General internal Medicine* 18**:** 609-616.

Strevens, P. (1984). International maritime English (Seaspeak). *Fachprache* 6**:** 2-10.

Stubbs, M. (1983). *Discourse Analysis: A Sociolinguistic Analysis of Natural Language*. Oxford: Blackwell Publishers Ltd.

Swales, J. M. (1990). *Genre analysis: English in academic and research settings*. Cambridge: Cambridge University Press.

Swales, J. M. (1991). Discourse analysis in professional contexts. *Annual Review of Applied Linguistics* 11: 103-114.

Swales, J. M. (2004). *Research genres: Explorations and applications.* Cambridge: Cambridge University Press.

Tannen, D. (1984). *Conversational style: Analyzing talk among friends*. New Jersey: Ablex Publishing Corporation.

Ten Have, P. (1995). Medical ethnomethodology: an overview. *Human Studies* 18: 245-261.

Ten Have, P. (1999). *Doing conversation analysis: A practical guide*. London: Sage Publications.

Ten Have, P. (2002). Sequential structures and categorical implications in doctor-patient Interaction: Ethnomethodology and history. Revised version of a paper read at the conference 'Structure and Emergence of professionalised "Praxis"', J. W. Goethe-Universität, Frankfurt, Germany, September 26 – 28, 2001.

Ten Have, P. (2004). *Understanding qualitative research and ethnomethodology*. London: Sage Publications.

The American Heritage Dictionary of English Language (Fourth Edition) (2009). Available at: http://www.thefreedictionary.com/viral+load. Accessed on 28/08/2011.

Thomason, S. G. (2001). *Language contact*. Edinburg: Edinburg University Press.

Todd, A. D. (1993). A diagnosis of doctor-patient discourse in the prescription of contraception. In: Todd, A. D. and Fisher, S. (Eds.). *The social organisation of doctor-patient communication*. (pp. 183-209). Norwood, New Jersey: Ablex Publishing Corporation.

Todd, A. D. and Fisher, S. (Eds.) (1993). *The social organization of doctor-patient communication*. Norwood, New Jersey: Ablex Publishing Corporation.

Traynor, M. (2006). Discourse analysis: Theoretical and historical overview and review of papers in the Journal of Advanced Nursing 1996-2004. *Journal of Advanced Nursing* 54(1): 62-72.

Trudgill, P. and. Hannah, J. (2002). *International English: A guide to the varieties of Standard English*. London: Hodder Headline Group.

UNAIDS/WHO (2008). AIDS epidemic update: December 2005. United Nations Programme on HIV/AIDS and the World Health Organisation.

van Dijk, T. (1999). Critical Discourse Analysis and Conversation Analysis. *Discourse and Society* 10: 459-460.

Varonis, E. M. and Gass, S. M. (1985). Non-native/non-native conversations: A model for negotiating meaning. *Applied Linguistics* 6**:** 71-90.

Vasseur, M-T., Broeder, P. and Roberts, C. (1996). Managing understanding from a minority perspective. In: Bremer, K., Roberts, C., Vasseur, M-T., and Simonot, M. and Broeder, P. (Eds.). *Achieving understanding: Discourse in intercultural encounters* (pp. 65-108). London: Longman.

Verhoef, M. and Smit, U. (2003). Global norms and local requirements for 'BSAE'? A pilot study of teachers' assessment and perceptions of learner texts. *Southern African Linguistics and Applied Language Studies* 21(3): 153-168.

Watermeyer, J. (2008) *Pills of wisdom*: *An investigation of pharmacist-patient interactions in a South African antiretroviral clinic*. (PhD Dissertation). University of the Witwatersrand: Johannesburg, ZA.

Watermeyer, J. and Penn, C. (2009). The organisation of pharmacist-patient interactions in an HIV/Aids clinic. *Journal of Pragmatics* 41: 2053-2071.

Wenger, E. (1998). *Communities of practice*. Cambridge, UK: Cambridge University Press.

Wetherell, M., Taylor, S and Yates, S. (2002). *Discourse as data: A guide for Analysis*. London and Thousand Oaks: Sage Publications.

Williams, N. and Ogden, J. (2004). The impact of matching the patient's vocabulary: A randomised control trial. *Family Practice* 21: 6.

Williams, M. S. (2006). Language diversity in the public health sector in the Cape Unicity: Policy and practice. (MA Thesis) Stellenbosch University: Stellenbosch, ZA.

Wodak, R. (2006). Medical discourse: Doctor-patient communication. In: Brown et al. *Encyclopedia of language and linguistics* (Second Edition). (pp. 681-687). Oxford, UK: Elsevier Ltd.

Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction.* London: Sage Publications.

Wright, S. (2004). *Language policy and language planning: From nationalism to globalisation*. Basingstoke, Hampshire: Palgrave Macmillan.

Wright, B., Sparks, K. L. and O'Hair, D. H. (2008). *Health communication in the 21st Century.* Malden, USA: Blackwell Publishing.

Wynn, R. (1995). *The Linguistics of doctor-patient communication: An analysis of the methodology of doctor-patient communication research.* Tromso: Novus Press.

Yeager, V. (2005). Beyond barriers: HIV prevention and treatment in the South African public sector: A Western Cape science communication case study. (MA Thesis). Stellenbosch University: Stellenbosch, ZA.

APPENDICES

Appendix 1: Consultation 1

1	**Doctor A:**	So you think this should stop now, is it ok?
2	**Patient:**	When they go there?
3	**Doctor A:**	Y:e:s
4	**Patient:**	they just go to to clean up for I don't know what can I say, is just to clean themselves
5	**Doctor A:**	Y:e:s ok
6	**Patient:**	So you see
7	**Doctor A:**	So you did speak to her about HIV but you didn't tell her about your status?
8	**Patient:**	Ah not about the status
9	**Doctor A:**	Ok alright ok oh how do you feel about ARVs because I see P has been giving you counselling about ARVs :::? A::nd she spoke to you about having to start ARV:::s?
10	**Patient:**	Y:e:s, yes
11	**Doctor A:**	What is your feeling about it?
12	**Patient:**	A:i:I just because I::wow I eish you never stop errh to to to to of drinking the ARVs I refuse of it b'cos I can't eat errh carry on I can't eat errh so much errh a lot of errh of- of tablets 'cos sometimes errh I can't say agh errh I can't eat it I can't drink it but I will try that is why I feel so bad
13	**Doctor A:**	Are you worried about …
14	**Patient:**	Y:e:a:h and…
15	**Doctor A:**	the lots of tablets because it's gonna be five tablets a day eh?
16	**Patient:**	Then I was going to take it a long may be the whole life y'see
17	**Doctor A:**	Y:e:s, yes it's lifelong
18	**Patient:**	That is why I'm not feeling so good but it's nothing it's part of life I can carry
19	**Doctor A:**	Ok so you have this fear about going on this treatment fi::ve tablets a day for the r::e::st of your life eh?
20	**Patient:**	I can do it
21	**Doctor A:**	But on the other hand you want to
22	**Patient:**	Yes
23	**Doctor A:**	Ok S just quickly come over here. Would you like to sit on the b:e:d and let me quickly have a look at you? Can I can I quickly just have a look at you?
24	**Patient:**	Yes
25	**Doctor A:**	Ok sit on the bed ((background noise))
26	**Patient:**	I can do it
27	**Doctor A:**	Did you test for TB as well?
28	**Patient:**	Yes
29	**Doctor A:**	When was your test?
30	**Patient:**	two or three years
31	**Doctor A:**	And now are you having any pain or irritation when eating?
32	**Patient:**	No
33	**Doctor A:**	Ok did you notice those white things on your tongue?
34	**Patient:**	Yes
35	**Doctor A:**	Ok it doesn't look like thrush but it looks like what we call oral (hairy mucoplachae). It is a complicated name but it tells me that you are stage 3

36	**Patient:**	Uhm!
37	**Doctor A:**	Eh! We have HIV disease we have stage 1 no symptoms, stage 2 little bit of symptoms, stage 3 is when somebody has that white thing on the errh rear of the tongue if you look in the mirror you will see it. Just just you know I will just like to explain to you that if we if we start ARVs it is not for nothing ok? S can you get up((Background noise))
38	**Doctor A:**	Ooh this is a nice belt, did you buy it?
39	**Patient:**	(((unclear)))
40	**Doctor A:**	Oh is it a traditional belt?
41	**Patient:**	(((unclear)))
42	**Doctor A:**	Oh is it traditional? It's not for the looks?
43	**Patient:**	No
44	**Doctor A:**	Oh ((laughs)) what is it for? Is it the *jakals*
45	**Patient:**	Errh it's a what can I say, it is a it's a sea dog
46	**Doctor A:**	Eh?
47	**Patient:**	It is a sea dog
48	**Doctor A:**	Is it a seal?
49	**Patient:**	It's a dog that we have from the sea
50	**Doctor A:**	A dog from the sea. Is it a seal?
51	**Patient:**	Is a dog what can I say I don't know the name of the dog you know from the sea they have small dogs
52	**Doctor A:**	*Jakals*
53	**Patient:**	From the sea, we get from the sea
54	**Doctor A:**	Only at the beach
55	**Patient:**	At the beach
56	**Doctor A:**	But it's not a water animal
57	**Patient:**	It's a water animal
58	**Doctor A:**	It's a water animal ehm?
59	**Patient:**	Yeah
60	**Doctor A:**	Any pain?
61	**Patient:**	Nothing
62	**Doctor A:**	Ok, alright ((ruffle of paper and background noise))... (0.25). Alright if you were to start on ARVs when would you like to start?
63	**Patient:**	Uhmm, uhmm!
64	**Doctor A:**	((To nursing sister who enters laughing)) what now?
64	**Patient:**	This is March ((Background noise)) errh April neh?
66	**Doctor A:**	April?
67	**Patient:**	Is it too long?
68	**Doctor A:**	Eh?
69	**Patient:**	April, May
70	**Doctor A:**	Look I'm prepared to start you today because I always feel it's it's (ruffle of paper) it's better to start while you don't have any..., it's better to start before you have errh before you get any TB and get very ill... and we have your tablets here. Errh but if, I mean on the other hand I also don't want to push you. I don't want to push you if you don't feel ready yet. So I can give you another date errh and start in April if you feel better to start in April that is also fine
71	**Patient:**	So are you going to give me errh or am I going to get it here everyday here in clinic or I am going to get my couple of tablets to take at home or I'm going to come everyday?

72	**Doctor A:**	Errh ok. How the ARVs work is the first month we give you tablets for one month but we want you to come back in two weeks' time so that we can do safety bloods and check that you are coping well and you understand how to take the tablets errh and after that we see you are doing well, you understand exactly how to take the tablets and there are no problems then we give you a date for every month to come and collect the medication, alright?
73	**Patient:**	Alright
74	**Doctor A:**	If you need to go somewhere urgently say there is a funeral or something, we want you to PLEASE come in before hand and just arrange with the sisters so that we can give you extra tablets, so that you are never without ARVs, alright? Does that make sense?
75	**Patient:**	Ok (0.10)
76	**Doctor A:**	So you want to start next time?
77	**Patient:**	By next, by this month may be at the end of this month or next week I don't know I am going to Eastern Cape. Also may be I'm going to take three weeks there or more a month I don't know
78	**Doctor A:**	When?
79	**Patient:**	Then I come back
80	**Doctor A:**	Ok when are when are you coming back?
81	**Patient:**	Agh I don't know it depends to my mom because I'm going with my mom there. I don't know what when are we going but let me say let me say it going to be a month
82	**Doctor A:**	One month. So if I give you date for 1 April, does that work for you?
82	**Patient:**	Yes
84	**Doctor A:**	1st of April ((ruffle of paper opening and closing of door)) ((knock on the door)) ((to nursing sister who has just entered the room)) You! ((To patient)) Will you be able to give some sputums for (0.4) will you be able to give some sputums next time, aagh today, just to test for HIV aagh for for TB, hmm? Is that okay?
85	**Patient:**	ok (0.15) ((ruffle of paper))
86	**Doctor A:**	GREAT, I think I it's fine. I think it is a good decision, alright? ((To nursing sister)) S is gonna come back in on the 1st of April and we will see if we can start on ARVs then b'cos he's going away to the Eastern Cape for three weeks, okay, are you happy with things?
87	**Patient:**	I'm happy
88	**Doctor A:**	Ok superb, I'm just gonna send you out ((bang of door opening and closing)) This is only the white pills and the brown pills. The brown pills are vitamins and the white pills are just to prevent you from getting pneumonia okay? It doesn't treat the HIV okay. It's no treatment of the HIV okay. It's just to prevent pneumonia
89	**Patient:**	Hmm! So must I::, so it's also the tablets for the whole life or…?
90	**Doctor A:**	Oh no, the Bactrim and the Bco is only for until your CD4 is up again, alright? But the ARVs are the tablets of the whole life, yes! (0.4) BUT if you think of it I mean it's only five minutes in the morning and five minutes at night. You just have to remember about having HIV and taking your medicines and then in exchange they give you a normal life and errh so, please don't please do::n't let us start in April. I think it's a good time to start.
91	**Patient:**	yes, ma'am
92	**Doctor A:**	But don't defer it until late don't wait until you feel that you are very ill
93	**Patient:**	Ok

94	**Doctor A:**	Okay b'cos sometimes the body does not recover from those illnesses
95	**Patient:**	Ok. So, which means, I, for the idea of a wife, I can't take even a wife may be? ( )
96	**Doctor A:**	((Chukkles)) You can, everybody would like to have a wife so I think obviously you can `take a wife but I think before you start having sex it's important to speak to the wife so that she knows the whole truth about you errh you know, errh she knows aah I would feel that she needs to know that you have HIV so that she can also be tested regularly, alright for HIV. There are people where the wife is negative and the husband is positive but then you also have to approach it wisely, you know medically wisely
97	**Patient:**	But then how are we going to get may be the children or are going are we not going to get the children?
98	**Doctor A:**	I always like to test the wife as well, and make sure that your viral load is down and that you are stable on ARV treatment before you try for children. Ok and then I like to give advice to the wife and the husband together on when to have sex without condoms b'cos there is always a little chance that the wife will get HIV and then the child will have HIV, alright? But we can make the risk very low alright? But that involves a lot of visits and us speaking, you know speaking about what the best and safest way is, alright?
99	**Patient:**	Alright, I understand
100	**Doctor A:**	Okay?((Chuckles))
101	**Patient:**	It's fine
102	**Doctor A:**	Alright, did I give you your date on your card, where is your file?((ruffle of papers in file)) Alright so you will take this file to Sister M and she will draw blood from you and also collect sputum to just test for TB okay?
103	**Patient:**	Alright
104	**Doctor A:**	Okay, thanks a lot.

Appendix 2: Consultation 2

1	**Doctor A:**	Ok, I think it's alright. So you are happy that we record the conversation?
2	**Patient:**	Yes?
3	**Doctor A:**	Ok, alright let's just put the recorder on the side. Any complaints ((coughing)) any complaints today?
4	**Patient:**	I am coughing
5	**Doctor A:**	How long have you been coughing?
6	**Patient:**	I think it's a week now
7	**Doctor A:**	One week. Is it a dry cough or is there any sputum that comes out?
8	**Patient:**	Yes
9	**Doctor A:**	Colour?
10	**Patient:**	It's white
11	**Doctor A:**	Alright! Very nice feet (0.4). Any errh is your nose running at all?
12	**Patient:**	I'm having the flu
13	**Doctor A:**	Flu so you do have flu symptoms. Let's see how many months have you been on ARVs? Six months exactly! Did you ever have a pap smear?
14	**Patient:**	(((unclear)))
15	**Doctor A:**	Did you miss your appointment eh?
16	**Patient:**	They give me 27 of this month for Pap smear
17	**Doctor A:**	Ok, so you have an appointment ok (0.3) alright. Never had TB eh?
18	**Patient:**	No

19	**Doctor A:**	Alright ((ruffle of paper)) ok I see how did it go with taking the tablets? Ooh not so good this time, what happened?
20	**Patient:**	I don't know what happened
21	**Doctor A:**	Hmm? Is there a specific time you forget to take the tablets, hmm?
22	**Patient:**	So I think may be I take it but I didn't take it
23	**Doctor A:**	Hmm do you need a tick sheet again?
24	**Patient:**	I don't have a tick sheet
25	**Doctor A:**	But I mean would you like to have one again?
26	**Patient:**	Yes you can give it
27	**Doctor A:**	'Cos it's nice if you can remind yourself eh? You know how to use it eh?
28	**Patient:**	I've never used it again
29	**Doctor A:**	You've never used it again. Alright ok, it's still the same, D4t, 3TC and extra vitamins. I'm giving you two so you can just get into the habit again. If you can remember the dosages, one in the morning, one in the morning eh? And then at night one, one, one. What time are you taking it at night?
30	**Patient:**	I I take it 9 0'clock
31	**Doctor A:**	Nine o'clock. Have you taken this morning?
32	**Patient:**	Yes doctor
33	**Doctor A:**	Ok so today is the 18th of March neh? So I am writing the 18th of the third month and you can just tick like this errhm may be put this in the spot where you keep your tablets so every time you take your tablets you can just tick it
34	**Patient:**	the tablets I must tick it
35	**Doctor A:**	Y:e:a:h, just leave a pen there as well so that you can tick, because I would also get confused you know, whether I have taken it or not. And you can just go on 19/3, 20/3 you know, all the way down.
36	**Patient:**	So I must put the date and the time?
37	**Doctor A:**	Yes just or you can put what is today, Wednesday eh? Wednesday, this is YOUR paper to do as you please with ok. This is for your, for you, to help you. Do you have a pill box?
38	**Patient:**	Yes I do
39	**Doctor A:**	You have a pill box eh? So the pill box also has Monday, Tuesday, Wednesday,
40	**Patient:**	Ok
41	**Doctor A:**	So if you may be can stick to that, you know, take it from there it can also help you remember because the one problem I see you've always taken your medicine very well, hundred percent, 98% so it's just this time that it went down 88%. The problem is if you don't keep it over 95% ((clears throat)) then the virus gets a chance to grow and the virus can become resistant against the medicines. That means that the medicines may be will not be work any more in future alright? ((clears throat)). Anything you want to ask me?
42	**Patient:**	Can I have something for my face because my face is so dry and sometimes I even get a rash.
43	**Doctor A:**	Does it itch?
44	**Patient:**	Yes
45	**Doctor A:**	What do you use to wash your face with?
46	**Patient:**	Sunlight soap
47	**Doctor A:**	Hmm ok, may be for the moment just use aqueous cream. Don't use sunlight soap, use aqueous cream like soap alright, then I can give you errh cream to use on the chin... to you to use only once a day. I gonna give

		it to you. Ok, we didn't do... yes we did CD4 count last time ((ruffle of paper)). You WON'T BELIEVE IT! ((Laughs)) Take a wild guess
48	**Patient:**	3-7-0, 3-8-7
49	**Doctor A:**	387 eh? It's up from 251 eh? That's fantastic 387! And then the other thing we also check always is to check the virus, is it growing or not? And last month it wasn't growing, okay. It was lower than detectable limit. So that:: this is what we really wanted. We want the virus low and the CD4
50	**Patient:**	To be ((mumbles))
51	**Doctor A:**	Yes! Absolutely, that was on the 10th of Feb ok. Alright your card, do you have it in here? Let me just write this down for you as well eh, because it's nice for you to know 387 eh? ((ruffle of paper)) (0.18) How is it going, are you, you're working eh?
52	**Patient:**	Yes doctor but
53	**Doctor A:**	How is it going?
54	**Patient:**	They give me a problem there. They don't want to skip a day to not come at work. They give me a problem because I was a learner. We do the learnership for the training for the security, so for next month they are going to start for the practicals and so they don't want to miss the day so I don't know what I'm gonna do.
55	**Doctor A:**	Ok if you like you can just arrange with Sister M, alright? Errh they will just want to check what your, what your pill count was like. Next time errhm can you send somebody else?
56	**Patient:**	yes, I will send my mother
57	**Doctor A:**	Ok and she will bring the old pills along alright? So you can… may be do that for two or three times alright? Just, we like to see you every three or four months, and the doc and once the doctors will like to see you every six months. The reason is when we did your safety bloods we drew out blood to check the CD4, to check the HIV growth in February, we'd like to do that again in August, alright? August to July. Ok but just discuss it with Sister M so that she knows okay? ((Scribble on paper)) (0.20). Ok Sister M she can just give you that
58	**Patient:**	Should I give this to Sister M?
59	**Doctor A:**	Yes she can give you the tablets, agh, not the tablets the cream. So I just put it here ((ruffle of paper)), here we go, here are your tablets ok (0.25). Alright anything else you wanna ask me?
60	**Patient:**	Everything is fine
61	**Doctor A:**	Ok, alright, SUPER. See you then.
62	**Patient:**	By:e
63	**Doctor A:**	Bye Sweety

Appendix 3: Consultation 3

1	**Doctor A:**	So you're happy, I'm just going to say it again so it's on the recording. So you are happy to continue with the recording?
2	**Patient:**	Ah it's ok, it's alright
3	**Doctor A:**	It's just for research purposes. They look at language use if somebody is not using their first, their mother tongue okay? Errhm, just wanna see what the Sister wrote down here. Are you having any troubles today?
4	**Patient:**	Errh she she said in my blood, sorry, in my urine she noticed noticed some blood
5	**Doctor A:**	Yes. And it's been there last month as well eh?
6	**Patient:**	Sure
7	**Doctor A:**	Alright are you having any troubles, burning?

8	**Patient:**	Yeah sometime I feel that may be it would disappear. But I felt it
9	**Doctor A:**	Never any discharge from the penis?
10	**Patient:**	No discharge but that burning sensation I use to feel it
11	**Doctor A:**	Alright, hmm you are taking high blood pressure medication uhmm?
12	**Patient:**	Yeah, the first month I can't remember the date did they give me, first month?
13	**Doctor A:**	WHY?
14	**Patient:**	She said the test had actually improved. And errh I think it was during my first errh days when I when I took ARVs and then my system…since then
15	**Doctor A:**	Let me just see, did I ever put you on high blood medication? Yes, yes! ((ruffle of papers)) yes, yes! When did we start it?
16	**Patient:**	Errh I started taking in May which is 28 of May 2008, that is when I started taking it.
17	**Doctor A:**	Until when have you taken it?
18	**Patient:**	I'll put it errh roughly around November. I haven't taken those high blood pressure pills since November. I haven't taken them.
19	**Doctor A:**	Ok your blood pressure was high in October still
20	**Patient:**	I'll put it roughly December. I don't think I took the medicine since December. I haven't taken them (0.16)
21	**Doctor A:**	Alright, I mean today is also low 110/60. Errh but you were given tablets again eh?
22	**Patient:**	Yeah I think yeah! I've got the tablets
23	**Doctor A:**	The water tablets, you've been taking them for the last month?
24	**Patient:**	[Those]
25	**Doctor A:**	[High blood]
26	**Patient:**	Yeah, those small yellow tablets
27	**Doctor A:**	Yeah, you've been taking them?
28	**Patient:**	Ah I want to be honest, when it improved I, I, I, I don't know why but I just left it behind because I felt probably I was, my body was getting used to some of those things
29	**Doctor A:**	Ok I mean you don't, before the last month you haven't taken them eh?
30	**Patient:**	I never took them
31	**Doctor A:**	Great, then I believe you don't need them. We shouldn't be giving to you if you don't need it again eh? Let me just check you are almost a year on treatment eh? Ten months!
32	**Patient:**	Sure
33	**Doctor A:**	It's feels like years ((laughs))
34	**Patient:**	It's errh the 28 of errh [May
35	**Doctor A:**	[May]
36	**Patient:**	Yes. I think my, my, my biggest problem are just the itches. Ichy that remains my biggest problem
37	**Doctor A:**	That's your that's what is bugging you at the moment?
38	**Patient:**	Yes, itching
39	**Doctor A:**	Where?
40	**Patient:**	Eei, you see at times you end up scratching and especially when it heals up, uh?
41	**Doctor A:**	Ye::s?
42	**Patient:**	There is always that errh ah::: that thing that would always feel like it should be removed right? [There's...
43	**Doctor A:**	[There is] something underneath that needs to come [out]

44	**Patient:**	[Yes] like I was checking it, of course I was scratching it but this one actually healed quite quite well
45	**Doctor A:**	Uhm, uhm
46	**Patient:**	But such they actually present problems
47	**Doctor A:**	Is there any pus that's coming out or not is it more whi:te?
48	**Patient:**	No, no
49	**Doctor A:**	No pus
50	**Patient:**	Yes you see like this one, it healed but it remains like this hmm
51	**Doctor A:**	It's all over the body eh?
52	**Patient:**	It's almost, ye:ah, it':s
53	**Doctor A:**	But, ok alright
54	**Patient:**	A::nd hmm at times my my legs I feel errh more like heat, some kind of I feel like it's heating errh
55	**Doctor A:**	Pain?
56	**Patient:**	At times I feel like I'm sleeping on the bed right, it feels like it's heating up
57	**Doctor A:**	Okay no but errh no pain? No pain.
58	**Patient:**	Ah no, no pain. So this... when I scratch, this kind of thing this is what ends up happening even when I am feeling like scratching
59	**Doctor A:**	How long have you had those? ((dragging of feet on floor)) Show me the one on the ankle again?
60	**Patient:**	Yes (like this)
61	**Doctor A:**	This is also itchy neh?
62	**Patient:**	Y::es, it does itch
63	**Doctor A:**	It itches
64	**Patient:**	Yeah it itches
65	**Doctor A:**	Ok I just want to feel here; I just want to feel your groin. Is there any... do you want to lie on the bed may be?
66	**Patient:**	Yes
67	**Doctor A:**	((Screeching of bed)) No other problems hey? OK, right ( )
68	**Patient:**	Yes
69	**Doctor A:**	Ok, alright, I'm going to give you something for that ((screeching on the floor and ruffle of paper)) Ok today i::s the 18th. So I'm stopping these and I'm just adding a cream and I suggest you might just... here you... go you can apply some of that twice a day
70	**Patient:**	Sure
71	**Doctor A:**	To try and prevent you from scratching alright? I'm gonna give you some aqueous cream just to use it as soap alright, instead of using the soap to prevent the skin from being dry. You can also use a vegetable oil actually
72	**Patient:**	Vegetable oil?
73	**Doctor A:**	Y:e:s it's also good for the skin
74	**Patient:**	Sure
75	**Doctor A:**	But I'm gonna give you the aqueous cream alright? Have you had these before?
76	**Patient:**	Yes
77	**Doctor A:**	They look different now hey?
78	**Patient:**	Yes the first time I got these was last month
79	**Doctor A:**	Yes ok, we're gonna discontinue these
80	**Patient:**	Sorry?
81	**Doctor A:**	We're going to discontinue the high blood pressure tablets. I'll stop them
82	**Patient:**	Sure

83	**Doctor A:**	Errhm then we can do the uhm bloods next month hey?'Cos you are almost a year on treatment hey? Just uhm the other thing that I could do, I suspect that that is PPE ok? That's something that is associated with HIV alright?
84	**Patient:**	Yes
85	**Doctor A:**	Uhm. I really don't think it's anything more worrying than that. But to be on the safe side we can make an appointment with a skin specialist and they just take a small, small, they take one lesion they take it out, they send it away to the lab, they have a look under the microscope and tell you exactly what it is. Would you like that?
86	**Patient:**	Yes, exactly
87	**Doctor A:**	Ok alright ( ) Alright, how's it how's it going otherwise? Are you working?
88	**Patient:**	Yes I am working and it is ok I think. Probably a good three or so months if God so wish, probably I can buy my small car this time around
89	**Doctor A:**	You gonna buy a sofa?
90	**Patient:**	Yes, I want to buy may be a pick-up truck. I think I can
91	**Doctor A:**	Ok, do you want to use it in the business or?
92	**Patient:**	I really want you know, that is what I'm looking forward to
93	**Doctor A:**	Ok
94	**Patient:**	Yes b'cos I've worked for long so I want to
95	**Doctor A:**	Super, super! Second hand cars are actually quite cheap these days hey? 'Cos people are ((thanks W)) because people are actually struggling hey to pay cars. So people, one can actually do quite well with getting a second hand car or… yeah
96	**Patient:**	Yeah second hand. I'm not worried if it's a second hand car as long as it is a pick-up truck
97	**Doctor A:**	Great, GREAT, it's excellent news. (0.22) Alright, do you have the nice green card already?
98	**Patient:**	Yes I have already. Yes I think errh, it must be
99	**Doctor A:**	Is it in here?
100	**Patient:**	It must be or it could be
101	**Doctor A:**	Ok it's actually quite nice to be able to give it as errh as a passport sort of hey because then everybody understands... ((addresses the nursing sister in Afrikaans)) ((flipping of pages in the file)) (0.27) Errh it was October last year? Anything else you wanna ask me?
102	**Patient:**	Yeah uhm yeah basically [that is
103	**Doctor A:**	[That is] the one thing that's bugging you hey?
104	**Patient:**	yes, especially with the hardening of the skin where you might feel itchy you find that at times when it ends up hardening like this and it might stay for a week, two weeks but then you actually feel the itching later
105	**Doctor A:**	Ok
106	**Patient:**	Yes
107	**Doctor A:**	Uhm, what type of work do you do?
108	**Patient:**	Ok you know, errhm there is uhm professionally I am a, I am a high school teacher right?
109	**Doctor A:**	Y:e:s
110	**Patient:**	I am a High School teacher
111	**Doctor A:**	Yeah
112	**Patient:**	But when I came here I teach Economics, Business Studies sometimes others I haven't been able to find the one in the High schools
113	**Doctor A:**	Yes

114	**Patient:**	But so you see what I do I look for a security job I got it so normally I do that by night. During the day there is a small college in Bellville where I go and errh teach at so normally
115	**Doctor A:**	Economics?
116	**Patient:**	I do teach Economics there I also teach in other areas like police law
117	**Doctor A:**	Y:e:s
118	**Patient:**	Traffic signs and traffic law enforcement
119	**Doctor A:**	Yes?
120	**Patient:**	All these duties that are done by the Metro Police and satellites
121	**Doctor A:**	Okay?
122	**Patient:**	Yes
123	**Doctor A:**	So you're doing two jobs at the moment
124	**Patient:**	That's what I do
125	**Doctor A:**	Ok but you are not using your hands in any... or
126	**Patient:**	Sorry?
127	**Doctor A:**	You're not using your hands in any do you use a lot of chalk?
128	**Patient:**	No, no it's errh it's these these markers, yes
129	**Doctor A:**	Ok yeah, yeah, yeah ha! Ok shall I give this along to you because it says sister has to fill this for a date?
130	**Patient:**	Yes
131	**Doctor A:**	She will probably bring it back to me because she would want me to file it in the file
132	**Patient:**	Ok so I will come back for for this one?
133	**Doctor A:**	Yes just for an appointment. It won't be within the next month
134	**Patient:**	Ok sure
135	**Doctor A:**	((laughs)) I'm going to give this to her and also write some Aqueous cream... and then also the dermatolology appointment alright. Ok? Here we go and 14th of four
136	**Patient:**	14th of April
137	**Doctor A:**	Yes you can give that to her, let's just check how many tablets you have left. Uhmm yeah we'll make it 14 of four ok just to draw bloods and everything on that day
138	**Patient:**	Sure
139	**Doctor A:**	Superb! That's it ((laughs)) And we'll have a look at the results in May then, and hopefully it ( )
140	**Patient:**	Sure thank you
141	**Doctor A:**	Okay?
142	**Patient:**	Sure

Appendix 4: Consultation 4

1	**Researcher:**	The consultation is done in English
2	**Doctor B:**	Does she understand English?
3	**Researcher:**	Yes she does
4	**Doctor B:**	So there's no need for this page? ((Indicating the patient's copy of the consent form))
5	**Researcher:**	No it's your copy
6	**Patient:**	This is my copy?
7	**Researcher:**	Yes
8	**Patient:**	Alright
9	**Doctor B:**	Hello, how're you?
10	**Patient:**	I'm fine, Sisi
11	**Doctor B:**	How long are you on treatment?

12	**Patient:**	Since I was start errh treatment I don't have a problem
13	**Doctor B:**	How long are you on treatment?
14	**Patient:**	Fi::ve months now.
15	**Doctor B:**	[Since October last year]
16	**Patient:**	[Yes since October last year]
17	**Doctor B:**	No problems?
18	**Patient:**	No problems doctor
19	**Doctor B:**	You are not losing weight?
20	**Patient:**	No, agh-agh but I am coughing now. But I need a syrup for coughing
21	**Doctor B:**	We don't keep syrups for coughing. What comes out when you cough?
22	**Patient:**	Now not today, I make a test for TB and spit but I am still waiting for the result but I think that the result is supposed to out next week but I am not sure
23	**Doctor:**	Uh:m? But how long are you coughing now?
24	**Patient:**	I have two weeks now
25	**Doctor B:**	Uh::m for two weeks but are you losing any weight?
26	**Patient:**	Nothing, ah ah but especially in the night
27	**Doctor B:**	Uhm, ok but you are not losing weight are you?
28	**Patient:**	Ah-ah
29	**Doctor B:**	What is the weight? Sister N we didn't weigh you
30	**Patient:**	We did
31	**Nursing Sister:**	I did ((laughs)) Ho-ho, didn't I write it? Kom kom
32	**Patient:**	How much was your weight today? Did you weigh?
33	**Nursing Sister:**	I weighed her
34	**Doctor B:**	How much did you-she
35	**Nursing Sister:**	Seventy-six, sixty-nine, seventy-nine
36	**Doctor B:**	But how much was it today, do you remember?
37	**Patient:**	Ah-ah I couldn't tell her
38	**Nursing Sister:**	I wrote it ((laughs)) ((opening and closing of door))
39	**Doctor B:**	She is going to weigh
40	**Patient:**	Oh ok
41	**Doctor B:**	Ok so your weight has come down a little bit. So we'll have to wait for the… for the sputum results hmm?
42	**Patient:**	Yes, yes, I'm still waiting
43	**Doctor B:**	Hmm? Ok anything else that bothers you? Because your results are fine eh. Your liver enzymes are a little bit high
44	**Patient:**	Hmm
45	**Doctor B:**	But they always... talk to; talk to nurse we'll have to repeat them today. You are not drinking any alcohol are you?
46	**Patient:**	Nothing no, no
47	**Doctor B:**	Hmm ok, alright let me just listen to your chest quickly. Sit here
48	**Patient:**	Ok ((screeching of chairs and closing of door))
49	**Doctor B:**	Up, alright. Let me see your mouth. Uhmm ok. ((Addresses the nurse in Xhosa)) Are you working?
50	**Patient:**	Yes, yes I'm working
51	**Nursing Sister:**	She's a warrior
52	**Doctor B:**	Uhmm?
53	**Nursing Sister:**	She's a warrior. So very anxious about home
54	**Patient:**	So the other problem I want to ask neh?
55	**Doctor B:**	Uhmm

56	**Patient:**	On 4th of April neh, I will get married so I
57	**Doctor B:**	You are getting married?
58	**Patient:**	Yes
59	**Doctor B:**	Wow that's great! Are we invited Sister?
60	**Patient:**	In Cape Town anyway not here in Paarl, but it's fine you can go to ((laughs)) my wedding. So Sister neh, so I am making family planning. So now I decided to stop it neh because always I use a condom. The time I was start to use a condom it was last year the condom that we are using that time it was not safe because it was break. So that's why now I decided to stop it to use to err to make a family planning
61	**Doctor B:**	Are you you are not using family planning now?
62	**Patient:**	I'm still, yes I decided to stop it
63	**Doctor B:**	Wh-what did you stop? The injection?
64	**Patient:**	Yes, the injection
65	**Doctor B:**	Do you want a baby now?
66	**Patient:**	No I am not ready for a baby now. Not now, not now
67	**Doctor B:**	But why did you stop the injection then?
68	**Nursing Sister:**	But aren't you due? When are you due
69	**Patient:**	Sorry?
70	**Doctor B:**	She stopped it, she stopped it
71	**Patient:**	I want to stop it
72	**Nursing Sister:**	But WHEN are you due?
73	**Patient:**	It supposed that it's next month
74	**Nursing Sister:**	Next month neh?
75	**Patient:**	Hhm, uhm
76	**Doctor B:**	But you want to stop
77	**Patient:**	Yes
78	**Doctor B:**	But why do you want stop?
79	**Patient:**	I don't want to use the family planning any more
80	**Doctor B:**	Why?
81	**Patient:**	Because I'm still using the condoms
82	**Doctor B:**	Condoms break
83	**Patient:**	Which means they are not safe
84	**Doctor B:**	You know you are actually supposed to use both condoms and family planning if you don't want a baby. Condoms were basically errh errh recommended for infection, you know, to protect yourself against re-infection and other sexually transmitted infections. But if if for family planning you must you must use ehm something more reliable than the condom like an injection, neh. I would say carry on with it, why do you have problems with that?
85	**Patient:**	If I'm ready like I need a baby, it supposed that firstly it supposed that I consult my doctor neh?
86	**Doctor B:**	But what about your husband is he also on treatment?
87	**Patient:**	No, no. He is not positive. He is negative
88	**Doctor B:**	But then making a baby means you are going to expose him so it is something that you two must discuss together and for that kind of consultation you must actually come together as well. Discuss it at home, discuss the risks at home and then you can come with him and then we can discuss the risks with you.
89	**Patient:**	Ok
90	**Doctor B:**	Unless if you want to do artificial insemination, you know, he

		donates sperms and then we fertilise you errh you, erhm know, in the laboratory. But then you will have to pay from your own pocket .The state doesn't do that
91	**Patient:**	Ok, but it is too expensive
92	**Doctor B:**	I don't know, we will have to find out for you how much it is and who does it in the first place and how much it is.
93	**Patient:**	But I'm desperate, at least one baby ehm because I don't have.
94	**Doctor B:**	Yeah
95	**Patient:**	I know that I am positive and at least one.
96	**Doctor B:**	Yes but you must discuss it with your partner otherwise because if he becomes HIV positive he will blame you. But if he agrees that look you can afford artificial insemination and you are ready we can advise you on a few things. But then you must come with him neh, ok? But today eh sister I want us to repeat the ALT because it went up a bit. We gonna repeat your liver function test neh and then erhm we'll see you next month again just to see what it looks like
97	**Patient**:	Ok
98	**Doctor B:**	Alright? Good luck for your wedding
99	**Nursing Sister:**	((to Patient)) Thank the doctor
100	**Patient:**	Thank you doctor
101	**Doctor B:**	Alright so we'll see you next week. Otherwise your viral load is beautiful, it's lower than detectable. Your virus is still controlled and your CD4 has come down a little bit. I don't know what happened there because it was 223 at some stage and now it is 145 again. Remember we want to see your CD4 count going up.
102	**Patient:**	Uh:m
103	**Doctor B:**	Are you stressing a lot? Then we will check the results as well to make sure that you don't have TB neh?
104	**Patient:**	Ok
105	**Doctor B:**	Drink a lot of water. Erhm Sister, I'm just going to write Thymine for her as well although the lactate was just 2.4 she lost a bit of weight but just to make sure we don't run into problems with the lactate. Where is her blue file, she doesn't have a blue file? Oh is it that one? (0.5) Ok then Mama neh, next time you come you can come with your husband and then we can discuss your baby issues neh?
106	**Patient:**	No, but not this year, next year
107	**Doctor B:**	Whenever you are ready
108	**Patient:**	Ok, alright, it's fine

Appendix 5: Consultation 5

1	**Doctor B:**	Hello R, how are you?
2	**Patient:**	I'm fine
3	**Doctor B:**	Are you fine? Are you feeling better today?
4	**Patient:**	Yeah, I'm feeling, errh I'm feeling ok
5	**Doctor B:**	You're feeling ok today. When did we restart actually? Was it last time or, or when did you start AGAIN? You remember you: came back from ((name of country)) and errh
6	**Nursing Sister:**	Oh yes, ye:s, exactly
7	**Doctor B:**	Oh in January already, so it's already like two months?
8	**Nursing Sister:**	In January this year. ((What did you say again?))

9	**Doctor B:**	Are you on TB now?
10	**Nursing Sister:**	It's this one
11	**Doctor B:**	Oh this one they are actually confusing. You must choose a different colour ((Laughs)). Alright so what did we do the last time? We did a few bloods last time neh? HB of 7, your blood is a little bit low but you actually look better today. He looks better to me.
12	**Patient:**	[Ye:ah
13	**Nursing Sister:**	[Yeah]
14	**Doctor B:**	Is that how you are feeling as well, you also feel better?
15	**Patient:**	I'm better because my legs were swelling but it's ok
16	**Doctor B:**	You're getting better now. Did you see the dietician?
17	**Nursing Sister:**	Our own dietician only i::n ((they said next month))
18	**Doctor B:**	But you're eating well
19	**Patient:**	Yeah
20	**Doctor B:**	No but they must give us those Pilani things so we can give to our patients, some of them
21	**Nursing Sister:**	It's just yeah Sister, I asked the Sister next door, the TB Sister they have got no more of that program, that yellow, nothing, nothing. I think it's to do with the financial year.
22	**Doctor B:**	Hmm, hmm
23	**Nursing Sister:**	So come next month ( ) Yeah I'll ask her, don't worry about that
24	**Doctor:**	Hmm, ok the last time we did ((HIV/AIDS-related test)). I'm just going to check here hmm Sister
25	**Nursing Sister**:	Hmm
26	**Doctor B:**	We did iron studies ( ) 'cos this we already ((flipping of pages in folder and opening and closing of door)) (0.20). May be took the other blood to see why you don't have enough, why you don't have enough blood in your system neh, the red cells are very low
27	**Patient:**	Ok
28	**Doctor B:**	Hmm
29	**Patient:**	But my CD4 count i::s
30	**Doctor B:**	Is 38. it's also very low
31	**Patient:**	But it's ((laughs)) it's better because the last year it was 09
32	**Doctor B:**	(0.5) Oh it was lower than this
33	**Patient:**	Yeah, it was 09 ((ruffle of paper)) and the tablets which you are giving me is different from last year
34	**Doctor B:**	Well, we are just buying now from a different company
35	**Patient:**	Oka:y
36	**Doctor B:**	The tablets themselves are the same. Ok, we are just buying from a different company.
37	**Patient:**	Oka:y
38	**Doctor B:**	I don't see your results here, may be they are not in yet neh?
39	**Patient:**	Ok, but as I see errh I'm [feeling
40	**Doctor B:**	But, but you [look much better]
41	**Patient:**	Yeah, as I say I'm...(0.4)
42	**Doctor B:**	And the legs are not swelling any more neh? (0.7)
43	**Patient:**	Ah no
44	**Doctor B:**	Ok, just wanna have a look at you quickly. Let me see your legs. So you can feel your health is getting better now eh?
45	**Patient:**	Err this time it's much better
46	**Doctor B:**	You're much better. Open your mouth, stick out your tongue. Alright, you are not coughing?

47	**Patient:**	Ah no
48	**Doctor B:**	Let me just listen to your chest quickly. Sit here ((screeching of chair)) (0.10), breathe in, out, in out. I am happy as well. I think you are improving but you must not just stop treatment now like you did and just went to (name of country) umh?
49	**Patient:**	Ok ((Opening of door))
50	**Nursing Sister:**	You found that results?
51	**Doctor B:**	No it's not there may be it's in here
52	**Nursing Sister:**	I also looked that side
53	**Doctor B:**	We'll just wait for them
54	**Nursing Sister:**	If you want to sometime going to ((name of country)), back to ((name of country))
55	**Patient:**	A: a::h
56	**Doctor B:**	You must tell me, don't just disappear. Tell me, Sister, I intend going after Easter. That is what all the other clients I tell them when it's the first day, say tell me, when do you intend when is your passport expiring or whatever, when do you intend going and when do you intend coming back, you must tell us alright?
57	**Patient:**	Ok
58	**Nursing Sister:**	So you must be honest with us. I don't want you to start and stop, it doesn't work that way Sir
59	**Patient:**	Ok
60	**Nursing Sister:**	So whenever there is a need for you to go back to ((name of country)), you must tell me, Sister man, I intend to go that side, so that I can at least try to organise two months of supply for you so you don't run out of medication that side, do you understand?
61	**Patient:**	Ok
62	**Doctor B:**	Sister B, what date are we gonna give him? This is just two weeks' supply left I think.
63	**Nursing Sister:**	Uhmm
64	**Doctor B:**	I would like to see him in one month
65	**Nursing Sister:**	When do you want to see him?
66	**Doctor B:**	On the 17.
67	**Nursing Sister:**	Yes
68	**Doctor B:**	You can give, you can give him
69	**Nursing Sister:**	Yes, I'll give him. Keep it in here because neh she must make new files, yeah
70	**Doctor B:**	Ok alright then R you must carry on like that, drink your medication nicely neh. We haven't changed them. They are still your old tablets but we just now buy it from a different company, so they look different on the out side. If you read the names, the names are still the same. We haven't changed anything
71	**Patient:**	Ok
72	**Doctor B:**	Alright? Ok but you must eat well and then I will see you again on the 17th of April but Sister will see you in two weeks I think, neh?
73	**Nursing Sister:**	No
74	**Patient:**	Around three
75	**Doctor B:**	On the 3rd you would come to see Sister to fetch your medication and then I will see you on the 17 eh? I will see you on the 17, ok?
76	**Patient:**	Ok
77	**Doctor B:**	Alright bye-bye

Appendix 6: Consultation 6

1	**Doctor B:**	Ok hi S, how are you?
2	**Patient:**	I'm fine
3	**Doctor B:**	I'm Doctor H. you've never met neh?
4	**Patient:**	Uhm
5	**Doctor B:**	Ok, uh:m, how long are you on treatment now?
6	**Patient:**	From January
7	**Doctor B:**	Which means two, just two months now neh?
8	**Patient:**	Uhm
9	**Doctor B:**	How is it going?
10	**Patient:**	((chuckles)) Better, much better
11	**Doctor B:**	Is it?
12	**Patient:**	Yeah
13	**Doctor B:**	Are you coping with your your times? So what time do you, how late do you drink your tablets?
14	**Patient:**	I drink 9.00 o'clock in the morning and nine in the night
15	**Doctor B:**	You're coping with that, you don't forget it?
16	**Patient:**	No
17	**Doctor B:**	Are you going, are you going to be able to drink it at 9.00 o'clock at night in the middle of winter?
18	**Patient:**	Yeah
19	**Doctor B:**	You don't go; you don't go to bed early?
20	**Patient:**	Yeah I'm always looking *Generations*. I know after *Generations* it's always
21	**Doctor B:**	Wait for 9.00 o'clock.
22	**Patient:**	Uhm
23	**Doctor B:**	Yes, it's very, the time is very important neh? Otherwise you're fine neh?
24	**Patient:**	Yeah, I'm fine. The only problem I've got is the, the pain in the back
25	**Doctor B:**	Uhum
26	**Patient:**	I've been in the hospital but they said I've got small kidney stone then they gave me tablets to drink for that
27	**Doctor B:**	Hmm, hmm
28	**Patient:**	but still I've got
29	**Doctor B:**	You must drink a lot of water you know that. With kidney stones, you must try to WASH them out. That's what you must, that is what you must do errhm
30	**Patient:**	((Is the errh pregnancy card with you?))
31	**Doctor B:**	Ee ((coughs)) ((You said you're pregnant?))
32	**Patient:**	Yes
33	**Doctor B:**	But when was, when was the treatment changed now? No two, ok in January ok, alright, fine. How far pregnant are you?
34	**Patient:**	They said it's sixteen weeks
35	**Doctor B:**	Sixteen weeks. When was it sixteen weeks? This week
36	**Patient:**	Hmm, yeah this week
37	**Doctor B:**	So the baby is not playing yet, you can't feel anything yet?
38	**Patient:**	No
39	**Doctor B:**	It should start any day now. From 16 weeks, it starts to play. It's very subtle initially. You've got kids?
40	**Patient:**	Yeah
41	**Doctor B:**	Oh so you know?

42	**Patient:**	Yeah
43	**Doctor B:**	Initially people don't really pick that up because it's subtle movement. You don't know if it's the GAS moving in your tommy or...
44	**Patient:**	((laughs))
45	**Doctor B:**	it's actually the baby moving but 16weeks, from 16 weeks you should actually start feeling something
46	**Patient:**	Hmm
47	**Doctor B:**	It gets stronger wi::th time ok, that's fine. How many kids do you have?
48	**Patient:**	Three boys
49	**Doctor B:**	Three boys. You are hoping for a girl but if it's not it's still the last one neh?
50	**Patient:**	Aaah the last one, yeah
51	**Doctor B:**	Ok, anyway
52	**Patient:**	there are no
53	**Doctor B:**	Hmm
54	**Patient:**	((laughs))
55	**Doctor B:**	Just not to stress
56	**Patient:**	((laughs along with the Nursing Sister))
57	**Doctor B:**	The feet are not swelling yet?
58	**Patient**:	Aaah they are all swelling
59	**Doctor B:**	Already?
60	**Patient:**	Yeah
61	**Doctor B:**	Oh you gonna struggle, you gonna struggle. Seven months and onwards
62	**Patient:**	((laughs)) Yeah
63	**Doctor B:**	Ok but I'm happy neh everything looks fine, so... ((Scribbling in file)) (0.10) Where do you stay?
64	**Patient:**	I'm stay at ((name of location))
65	**Doctor B:**	((name of location)), where is it?
66	**Patient:**	Here in ((name of area))
67	**Doctor B:**	Oh ok errhm ((scribbling on paper)) Sister we have to do ((the FPC)) again today neh?
68	**Nursing Sister:**	Hmm
69	**Doctor B:**	We check for errh… let's just see, ((FPC))...
70	**Patient:**	Doctor, they said I must ask my CD4 count. ( ) said I must ask my CD4 number. The last time I did it was in October and I think 193 but I'm sure it's up now
71	**Doctor B:**	We we only gonna we only gonna check your CD4 count again in July
72	**Patient:**	Oh
73	**Doctor B:**	Ok? So at the moment we are working with a one day picture any way, which wa::s
74	**Patient:**	A hundred and NINETY-THREE
75	**Doctor B:**	Yes and we're not gonna do it again, we're not gonna do it again until July
76	**Patient:**	Yeah
77	**Doctor B:**	Uhmm, what was it, where is it? Yes, 193. That was the last one neh? In July you wouldn't have delivered anyway then. So before you deliver, you will know you're your new CD4 count and viral load neh. ((coughs)) Just tell them we gonna do it in July.

78	**Patient:**	Hmm
79	**Doctor B:**	If you were gonna deliver soon then we'd feel some pressure to do especially your viral load but there is no urgency at the moment neh
80	**Patient:**	Hmm
81	**Doctor B:**	Alright, so we carry on neh? ((coughs)) OK I'm gonna see you on the 17th, ok, the Sister errh oh yeah the 17th. You're not working?
82	**Patient:**	No, I'm not working
83	**Doctor B:**	Ok, I just want to ((ruffle of paper))
84	**Patient**:	The 17th of which month April?
85	**Doctor B:**	Hmm, where are you going? Are you planning to go somewhere?
86	**Patient:**	Yeah, I want to go home for the Easter
87	**Doctor B:**	Ok where is home?
88	**Patient:**	((name of province))
89	**Doctor B:**	Arrange, arrange that with Sister neh?
90	**Patient:**	Yes
91	**Doctor B:**	I'm sure that you can arrange it ehm? Are you married to a Mosotho man?
92	**Patient:**	I was married to a Msotho man then he passed away
93	**Doctor B:**	Ooh. Can you speak Msotho
94	**Patient:**	Yes, I speak it fluently
95	**Doctor B:**	Really?((Addresses her in Mosotho: O a bua?)) – ((‘You speak Sotho?’))
96	**Patient:**	((laughs and responds in Mosotho: Ke a bua)) – ((‘I speak Sotho’))
97	**Doctor B:**	Now this lady wants us to speak in English when we could actually speak the language we both understand
98	**Patient:**	((Laughs)) Eh
99	**Doctor B:**	(Continues in Mosotho: Bana ba gago ba kae)) – ((‘where are your children?’))
100	**Patient:**	((Responds in Mosotho: Ba teng, ko skolong)) – they are here, going to school))
101	**Doctor B:**	Ok that's nice. Ooh see now, that's why I don't like this tape otherwise we could speak Mosotho. Now we are forced to speak
102	**Patient:**	English
103	**Doctor B:**	We're forced to speak English because this lady wants to understand us-the researcher wants to understand us
104	**Patient:**	Uhmm
105	**Doctor B:**	Alright the next time S we gonna speak Mosotho.
106	**Patient:**	Yeah
107	**Doctor B:**	When are you planning to come back?
108	**Patient:**	Errhm I just want to go for Easter and after Easter [I will come back
109	**Doctor B:**	[You will come back]. Are you taking the kids with?
110	**Patient:**	Yeah
111	**Doctor B:**	Ok alright so I'll see you then sometime when you get back neh?
112	**Patient:**	Yes
113	**Doctor B:**	Ok keep well neh?
114	**Patient:**	Thank you, doctor
115	**Doctor B:**	Ok bye-bye!

Appendix 7: Consultation 7

1	**Doctor B:**	Hi, how are you?
2	**Patient:**	I'm fine
3	**Doctor B:**	Ok, are you ready to start treatment today? Are you ready to start with your ARVs today?
4	**Patient:**	Today
5	**Doctor B:**	Are you ready?
6	**Patient:**	Yes
7	**Doctor B:**	Are you?
8	**Patient:**	Yeah
9	**Doctor B:**	How are you gonna take them?
10	**Patient:**	Errh
11	**Doctor B:**	Did they teach you? Did they tell you about ARVs?
12	**Patient:**	Yeah
13	**Doctor B:**	What did they say?
14	**Patient:**	They said errh I must take them, if I used to take them by six o'clock in the morning...
15	**Doctor B:**	Hmm
16	**Patient:**	I must also take them by six in the evening
17	**Doctor B:**	So what time have you chosen now for yourself?
18	**Patient:**	Myself, I've chosen to take them by:: five o'clock
19	**Doctor B:**	You gonna take them at five o'clock?
20	**Patient:**	Yes
21	**Doctor B:**	Why so early?
22	**Patient:**	Yeah because I go to work
23	**Doctor B:**	Where do you work?
24	**Patient:**	Errh I am a casual worker at a certain construction company
25	**Doctor B:**	Construction company. Do you work on weekends?
26	**Patient:**	Some of the weekends
27	**Doctor B:**	So when you're not working, what are you gonna do?
28	**Patient:**	When, when I'm not working?
29	**Doctor B:**	Yeah
30	**Patient:**	I can just take them by that time
31	**Doctor B:**	So you ARE going to wake up. You're neh, you are going to wake up for them
32	**Patient:**	Yeah
33	**Doctor B:**	It's still going to be five even if you are not going to work you realise that? I just want you to be... to realise that neh
34	**Patient:**	Ok
35	**Doctor B:**	Ok five o'clock when you're going to work it's gonna be easy because you have to wake up and go to work but when you are OFF you've still gonna wake up early to drink it at five o'clock
36	**Patient:**	At five o'clock it it agh it would be day time
37	**Doctor B:**	Uhm
38	**Patient:**	Five o'clock I will be I will be awake
39	**Doctor B:**	Even when you are not going to work. I just want to make you aware that even when you are not going to work you're still gonna wake up at the usual time so that you can drink your medication on time otherwise it's not gonna work neh?
40	**Patient:**	Yeah
41	**Doctor B:**	Neh cos WE don't choose your time. We want you to choose your time that you will be able to adhere to, to to you know to

42	**Patient:**	Take those tablets
43	**Doctor B:**	Yes so five is five. Five in the morning and five in the evening
44	**Patient:**	Uhum
45	**Doctor B:**	Neh? Ok if you are sitting in a taxi at five o'clock you gonna take them in the taxi at five o'clock ok?
46	**Patient:**	Ok
47	**Doctor B:**	Are you married?
48	**Patient:**	Yes
49	**Doctor B:**	How old are you?
50	**Patient:**	I a:m thirty::s:
51	**Doctor B:**	Thirty-three now
52	**Patient:**	Yes
53	**Doctor B:**	Where is your wife?
54	**Patient:**	Yeah she's in ((name of country))
55	**Doctor B:**	Ok, how many children do you have?
56	**Patient:**	Er:r:h I have got three
57	**Doctor B:**	Ok, now is your wife tested as well?
58	**Patient:**	No
59	**Doctor B:**	Why not?
60	**Patient:**	Not yet
61	**Doctor B:**	Did you tell her that you are HIV positive? Does she know?
62	**Patient:**	Yes, yeah
63	**Doctor B:**	She knows. You told her
64	**Patient:**	Yeah
65	**Doctor B:**	She must test neh?
66	**Patient:**	Yeah
67	**Doctor B:**	How old are the kids?
68	**Patient:**	Uhm one of then is fifteen years
69	**Doctor B:**	The big one
70	**Patient:**	Yes
71	**Doctor B:**	And then the second one?
72	**Patient:**	Hmm 14 ah 13
73	**Doctor B:**	Uhum and the little one?
74	**Patient:**	Uhm one year, and one year and two months
75	**Doctor B:**	She must be... The little one especially must also be tested neh?
76	**Patient:**	Ok
77	**Doctor B:**	Ok but are you having any problems at the moment?
78	**Patient:**	Agh
79	**Doctor B:**	Are you feeling well?
80	**Patient:**	But I'm just developing some spots
81	**Doctor B:**	Uhm
82	**Patient:**	Spots like errh
83	**Doctor B:**	But you're not on TB treatment neh? TB treatment- you are not on TB treatment?
84	**Patient:**	Yes
85	**Doctor B:**	You're not
86	**Patient:**	No, I'm not
87	**Doctor B:**	Have you ever been on TB treatment?
88	**Patient:**	No
89	**Doctor B:**	No ok. You are not coughing?
90	**Patient:**	No
91	**Doctor B:**	You are not sweating at night?

92	**Patient:**	Yes
93	**Doctor B:**	You are not allergic to any medication neh?
94	**Patient:**	No I'm not
95	**Doctor B:**	Ok let me just have a look at you quickly. Show me your spots
96	**Patient:**	Here
97	**Doctor B:**	Just in the head neh?
98	**Patient:**	Yeah in the head
99	**Doctor B:**	Just sit here sit here. Take off your jacket quickly
100	**Patient:**	((Ruffle of clothes))
101	**Doctor B:**	Let me listen to your chest. Nice deep breath ((uhurr))
102	**Patient:**	((Breathes))
103	**Doctor B:**	Again
104	**Patient:**	((Breathes))
105	**Doctor B:**	Again ((noise from closing of door))
106	**Patient:**	((Breathes))
107	**Doctor B:**	And your tummy it's alright?
108	**Patient:**	It's alright, it's ok
109	**Doctor B:**	You are not taking traditional medicine neh?
110	**Patient:**	Ah no
111	**Doctor B:**	You know you are not supposed to
112	**Patient:**	Uhm
113	**Doctor B:**	((Ruffling)) (0.42) You haven't lost any weight. Have you lost weight? Or is this your body?
114	**Patient:**	Yeah that's not
115	**Doctor B:**	Is this your usual?
116	**Patient:**	That's not the normal body
117	**Doctor B:**	Have you lost any weight?
118	**Patient:**	A little bit because errh I've been weighing 60kg
119	**Doctor B:**	Hmm, were you weighing 60?
120	**Patient:**	Yeah
121	**Doctor B:**	Today, you didn't hop on the scale today
122	**Patient:**	Ei:h I got I got on the scale
123	**Doctor B:**	Today, what did you what did you weigh today because I think they forgot to write here? Do you remember?
124	**Patient:**	Didn't they write it there?
125	**Doctor B:**	Ehm, do you remember what it was?
126	**Patient:**	Errh it was also 60,
127	**Doctor B:**	Was it 60 today?
128	**Patient:**	Yeah because they saw I'm not losing weight. I'm just
129	**Doctor B:**	Are your clothes fitting you the usual way?
130	**Patient:**	Sweating?
131	**Doctor B:**	The clothes are fitting the way you used to?
132	**Patient:**	Yeah
133	**Doctor B:**	((Scribbling))(0.8) So you are ready to start, we are starting today neh?
134	**Patient**:	Ok
135	**Doctor B:**	(0.15) ((opening and closing of door and more scribbling)) Did you order for him Sister? Let me see
136	**Nursing Sister:**	Yes all the medication is here
137	**Doctor B:**	(0.10) Do you need a letter for work H?
138	**Patient:**	A letter?
139	**Doctor B:**	Hmm.

140	**Patient:**	Yes I need it
141	**Doctor B:**	You need a letter for work?
142	**Patient:**	Yes
143	**Doctor B:**	Do you need a letter to say you were here today?
144	**Nursing Sister:**	A letter work, are you working?
145	**Patient:**	Yeah I'm working ((ruffling paper)) Agh but I told them yesterday that errh
146	**Doctor B:**	So you won't be needing a letter
147	**Patient:**	Yeah no problem
148	**Doctor B:**	Ok so we're gonna start treatment. I'll see you on the 17th of April, Sister's gonna see you on the 2nd of April neh
149	**Patient:**	Ok
150	**Nursing Sister:**	Can I have your card please, Sir?
151	**Patient:**	My what?
152	**Nursing Sister:**	Your card
153	**Patient:**	Card

Appendix 8: Consultation 8

1	**Doctor C:**	Great, are we ready to start? This we can just is that your pen?
2	**Researcher:**	Yes
3	**Doctor C:**	P, I doubt if you'd help if we can just
4	**Patient:**	Ok
5	**Doctor C:**	Yeah but we won't put your name on the system and things like that. We'll just carry on. Ok how are you today?
6	**Patient:**	Hey Doctor, I'm fine
7	**Doctor C:**	Is it?
8	**Patient:**	Hmm but now my problem it's just the feet
9	**Doctor C:**	Yes?
10	**Patient:**	But not all the time. If I can may be doing washing for a long time it's starting to pain
11	**Doctor C:**	Uhm
12	**Patient:**	It doesn't want me to stand for a long time
13	**Doctor C:**	Is it? Is it getting worse or is it the same?
14	**Patient:**	Sorry?
15	**Doctor C:**	Is the pain in the feet getting worse or is it getting better?
16	**Patient:**	Ah-ah, it's not worse
17	**Doctor C:**	It's not worse
18	**Patient:**	A:ah I'm sure it wants to start to, to pain now
19	**Doctor C:**	Is it?
20	**Patient:**	But it's it's not all the time
21	**Doctor C:**	Not all the time and it's feeling a bit better
22	**Patient:**	Uhm
23	**Doctor C:**	There's usually three things that cause the pain in the feet; the one thing is errhm when your… the HIV itself
24	**Patient:**	Yes
25	**Doctor C:**	The viruses can damage the small nerves in the feet and then it causes problems but when we start killing the virus that WILL get better. The other reason is some of the treatment that we're giving you…
26	**Patient:**	Hmm
27	**Doctor C:**	can cause the nerves to be damaged okay?
28	**Patient:**	Hmm

29	**Doctor C:**	Now I think the doctor wants to give you less one of the tablets, the dose is going to be less okay?
30	**Patient:**	Yes
31	**Doctor C:**	And then the third thing is if you are not eating well and you don't get enough vitamins. How are you eating?
32	**Patient:**	Uhmm with food I'm alright. I'm eating
33	**Doctor C:**	You are alright?
34	**Patient:**	((chuckles)) I am hungry just now
35	**Doctor C:**	((laughs)) You are hungry now? Ok I see you were 46 kilos when we started and you are 50 kilos now. That's good
36	**Patient:**	Yes
37	**Doctor C:**	Do you think the medicine is good for you?
38	**Patient:**	Yes it's good for me doctor
39	**Doctor C:**	Is it?
40	**Patient:**	Serious
41	**Doctor C:**	Is it? You feel better. You're stronger with that
42	**Patient:**	Serious
43	**Doctor C:**	Is it? Ok
44	**Patient:**	Hmm
45	**Doctor C:**	I just want to check and you take your medication everyday at the same time? What time do you take your medication and things?
46	**Patient:**	It's errhm at 8 o'clock early and 8 o'clock later
47	**Doctor C:**	Is it?
48	**Patient:**	Hmm
49	**Doctor C:**	And it's working for you
50	**Patient:**	Yes
51	**Doctor C:**	Did you... are you also working over the weekends
52	**Patient:**	Yes on weekends every day
53	**Doctor C:**	Every day and things like that
54	**Patient:**	Hmm
55	**Doctor C:**	Ok what are you planning for Easter? Are you going to stay here or you are going home?
56	**Patient:**	Ah-ah, I'm I'm going to stay here:
57	**Doctor C:**	You're not going home
58	**Patient**:	A:h, I'm not going home
59	**Doctor C:**	Ok doctor told you about your good CD4 and viral load last time hey?
60	**Patient:**	Yes
61	**Doctor C:**	Uhmm 24. Ok uhmm ((sneezes)) sorry, sorry. the last time I saw you ah, last time Doctor saw you , she is not here today
62	**Patient:**	Yes
63	**Doctor C:**	She's gone. Errhm she checked to see if your iron and everything is fine and that was ok. So I just want to write errhm ((vitamins B12 normal and iron also normal)). Ok, how are the children doing? Any problems with the children?
64	**Patient:**	Mhh-mh
65	**Doctor C:**	Is it? They are all happy
66	**Patient**:	Yes
67	**Doctor C:**	How old are you?
68	**Patient:**	I am errh 49
69	**Doctor:**	49 ok, so you don't plan more children hey?
70	**Patient:**	Mhh-mh

71	**Doctor C:**	Sister do we have her treatment here?
72	**Nursing Sister:**	I think so, yes
73	**Doctor C:**	They have reduced her, they have reduced her…
74	**Patient:**	from 40
75	**Doctor C:**	to 20 ok. We just need to go through your tablets ((to make sure it's better there)), okay?
76	**Patient:**	Ok
77	**Doctor C:**	((ruffle of paper))
78	**Patient:**	It's from Friday to
79	**Doctor C:**	Ah two weeks. I'll put it in the book. Ok, errhm P let's just see do you have your tablets with you?
80	**Patient:**	Yes I do
81	**Doctor C:**	Then we'll just have a look and see what we're going to change ((crackle of tablets)) Ok so this one, let's see this one is staying the same ok? The Nevirapine is staying the same.
82	**Patient:**	Yes
83	**Doctor C:**	This one is Lamivudine and this is changing but it's the same one. But you can see we can open it. I'm going to open it
84	**Patient:**	Hmm
85	**Doctor C:**	You can see that although it looks like that, this is the purple one ((guess)). It's going to look like this in the future okay?
86	**Patient:**	Ok alright
87	**Doctor C:**	Okay? That one is that one, it's not the triangle any more
88	**Patient:**	Hmm
89	**Doctor C:**	It's that one. You will see that it's Lamivudine Lamivudine
90	**Patient:**	Lamivudine yeah
91	**Doctor C:**	This is like Pick n Pay and this is like Checkers ((chuckles))
92	**Patient:**	((chuckles))
93	**Doctor C:**	Okay? Now this one is going to change a bit. You see on the one you have 20 and it stays 20.
94	**Patient:**	20
95	**Doctor C:**	Oh they have already done it
96	**Patient:**	Hmm
97	**Doctor C:**	So this is the smaller one, you take one of them hey? So you know them hey?
98	**Patient:**	Yes I know, yes
99	**Doctor C:**	Ok so that's basically perfect
100	**Patient:**	Yes
101	**Doctor C:**	So you have enough tablets
102	**Patient:**	Yes
103	**Doctor C:**	That's enough. Any questions?
104	**Patient:**	No, yes I errh ((smacking of mouth)) I filed a letter because I was errh getting sick pay, sick pay
105	**Doctor C:**	U::hm sick pay, yes?
106	**Patient:**	Yes so I file the letter errh this side
107	**Doctor C:**	Yeah
108	**Patient:**	Mara I've not finished yet to pay. I still have three months
109	**Doctor C:**	Yeah, so you will get up till May, you will get it till May
110	**Patient**:	Oh yes
111	**Doctor C:**	But then after May they are not going to give it longer.
112	**Patient:**	Alright
113	**Doctor C:**	So then you need to make a new plan

114	**Patient:**	Alright
115	**Doctor C:**	Are you going to have a job or something?
116	**Patient:**	NO
117	**Doctor C:**	But what did you think, how can you make money?
118	**Patient:**	Eish I don't know, doctor
119	**Doctor C:**	Is it? You must think of something ok because they don't give the grant for ever ok?
120	**Patient:**	Yes, doctor
121	**Doctor C:**	They are just stopping it and things
122	**Patient:**	Alright
123	**Doctor C:**	But you look like a clever lady. What work did you do before? Where did you work before?
124	**Patient:**	I was working at Northern Province to the Sun International
125	**Doctor C:**	SUN INTERNATIONAL?
126	**Patient:**	Yes
127	**Doctor C:**	At SUN CITY?
128	**Patient:**	At Thoyando
129	**Doctor C:**	Oh that side. What did you do there?
130	**Patient:**	I was a cleaner in the casino
131	**Doctor C:**	Ooh ok, ok and did you look for jobs here like that or not?
132	**Patient:**	I've been looking but I do:n't get it
133	**Doctor C:**	Do you have a letter from them, that you've done the work?
134	**Patient:**	No
135	**Doctor C:**	Because I think there's going to be a lot of hotels next year for the soccer and things like that
136	**Patient:**	Hmm
137	**Doctor C:**	And these hotels you must go and ask them and say, can I do that and things. People are doing well on their ARVs and they can have normal jobs and things like that
138	**Patient:**	Yes, yes
139	**Doctor C:**	And you don't need to feel like you have to tell people about the HIV
140	**Patient:**	Alright, yes
141	**Doctor C:**	Ok, if you are doing good as you are doing, we will make it that in future that you will only need to be here every second month and things like that ok?
142	**Patient:**	Hmm
143	**Doctor C:**	So she has still treatment for 9, 15, 9, so that means she has still another week's treatment. So she can come either in 4 weeks or 5 weeks
144	**Nursing Sister:**	Eh 4 weeks
145	**Doctor C:**	Four weeks. You can give the red thing if you want to and work out her system. ((M, would do that with other patients I think))
146	**Nursing Sister:**	21 April
147	**Doctor C:**	Okay, April 21 ((Closing folder)) (0.13) Ok P thanks eh? Nice seeing you and we'll see you on... nice Easter for you ok, we'll see you in April again ok?
148	**Patient:**	Ok
149	**Doctor C:**	And see if you can get a job then. See what you can do ok? Your feet will get better ok? Right!
150	**Patient:**	Ok
151	**Doctor C:**	Ok, alright.

Appendix 9: Consultation 9

1	**Doctor A:**	I just discussed this with the with the ARVs specialist ( )
2	**Patient:**	Uhum
3	**Doctor A:**	IT IS, IT IS puzzling the fact that your HB, your red blood cells, alright, your oxygen carriers….
4	**Patient:**	Uhm? Uhum
5	**Doctor A:**	that they're dropping so quickly. Erhm, you do feel much better today
6	**Patient:**	Yes
7	**Doctor A:**	What I want to do is I just want to have these bloods that we took today that we collected; I just want them to be followed up next week. So I'm going to ask you to come again next week. Is that alright? I won't be here it will be a different doctor
8	**Patient:**	Alright
9	**Doctor A:**	because I will be going on maternity leave
10	**Patient:**	Ok
11	**Doctor A:**	But it's, it's about those results. We just have to check up on those results
12	**Patient:**	Ok
13	**Doctor A:**	For the moment, you are stable, you know. The coughing is it severe or it's just...
14	**Patient:**	It started [yesterday
15	**Doctor A:**	[yesterday] alright
16	**Patient:**	But it's painful here [on throat
17	**Doctor A:**	[on the throat] ( )(0. 15)((say a-ah))
18	**Patient:**	A:a:h
19	**Doctor A:**	It looks slightly red (0.5).We're going to continue with those medications alright? Initially it is fairly common to have a little bit of an upset stomach to go with those medications alright?
20	**Patient:**	Ok
21	**Doctor A:**	But the low blood is NOT to be explained. That might be a delayed effect from the previous drug you were on
22	**Patient:**	Hmm
23	**Doctor A:**	Ok?
24	**Nursing Sister:**	((Speaks in Afrikaans: Dokter, ek soek die… die…-Doctor, I'm looking for the...the...))
25	**Doctor A:**	Hmm ((Responds in Afrikaans: …Die groen storie... vra vir Viola. Waar is haar…? Haar?-The green story...ask Viola. Where is her...her...))
26	**Nursing Sister:**	((Continues in Afrikaans: Dinge s'n is groen, hey?- Hers is green, hey?))
27	**Doctor A:**	((Responds in Afrikaans: Ja, ek weet nie waar dit is. Dit lyk of die file is weg))
28	**Patient:**	So my blood pressure is still low?
29	**Doctor A:**	Your blood pressure is good
30	**Patient:**	O:oh it's good
31	**Doctor A:**	Alright? ((Sound of falling instruments)) O:oh
32	**Nursing sister:**	((Speaks in Afrikaans: *unclear*))
33	**Doctor A:**	((Responds in Afrikaans): *Nee, nee* she came with that (Wat is daar bo? Die groen file was nie hier nie, hoor?-What is on there? The green file was not here ok?))
34	**Nursing Sister:**	((Speaks in Afrikaans: *unclear*))
35	**Doctor A:**	Ok, you have a date on the 8th of April, can I make it earlier?
36	**Patient:**	Uhum
37	**Doctor A:**	for the 1st, is that alright?
38	**Patient:**	Ok
39	**Doctor A:**	((Flipping of pages)) I'm actually very interested to know what is going on (0.27) erhm you just need to get your (medicine). Just ask from Sister. It

		is... it is written in here alright? And if you can give this to Sister M ((Addressing Nursing Sister in Afrikaans: Ja, ek weet nie waar dit is. Dit lyk of die file is weg-I don't know where it is. It looks as though the file is lost.))
40	**Nursing Sister:**	((Responds in Afrikaans: Dankie, hy's baie-Thank you, he's very...))
41	**Doctor A:**	If you can just give that to sister M and she will give you the antibiotic, alright?

Appendix 10: Consultation 10

1	**Doctor C:**	Hello ( ) the telephone fan, we'll just carry on. Err::hm ok P, I am just filling in the form now hey?
2	**Patient:**	Hmm
3	**Doctor C:**	It's Stallawan-nania neh?
4	**Patient:**	Yes
5	**Doctor C:**	In Franschoek, you're going to take it to the Franschoek office eh?
6	**Patient:**	Yes (0.17)
7	**Doctor C:**	((ruffle of paper) Ok I want you to sign here again and put your name again ((fllipping of papers)) (0.45). Ok so we'll see you in two-weeks' time again ok?
8	**Patient:**	Ok

Appendix 11: Consultation 11

1	**Doctor A:**	Ok so I'm just going to repeat that again you are happy that we record this conversation neh?
2	**Patient:**	Yes
3	**Doctor A:**	Ok, alright. Errhm let's have a look; you are exactly one year on treatment and errh ((let's have a look here)). Ooh alright, we requested a...we did a CD4 count ((bang of door)) last time and the CD4 is 271 and it was done twice. We asked for a CD4 count and a viral load, and instead two CD4s were done. Ok, alright ((chuckles)) that doesn't matter. I think that was done on the same day? Nee this was done last week, alright. Ok, so your CD4 is round about 270-280 because the one we did was 271 and the other one is 285 and if we look where it was it came up all the way from 30 in 2007, uhm it came up all the way from 30 in 2007 and was 242 in August(0.5) alright? So are you happy with that?
4	**Patient:**	( )
5	**Doctor A:**	Are you happy with your CD4 of 271
6	**Patient:**	((speaks in Xhosa: 30? *unclear*))
7	**Nursing Sister:**	((responds in Xhosa: Uthi isuka ku-30 ngoku)) – ((She says it has risen from 30))
8	**Doctor A:**	What is she saying?
9	**Nursing Sister:**	((Speaks in Afrikaans; *unclear)*)
10	**Doctor A:**	Ok ((responds in Afrikaans: Dankie, hy's baie ….*unclear*))
11	**Patient:**	((Continues in Xhosa: *unclear*))
12	**Doctor A:**	( ) ((The script needs to be altered on the green script on envelop)) ((chuckles))
13	**Nursing Sister:**	Oh yeah
14	**Doctor A:**	Ok thanks alright. What was she saying?
15	**Nursing Sister:**	Ok first of all she was asking why the two CD4 counts was two but while she was draw the blood on the same day

16	**Doctor A:**	Aah it was not on the same day and... NO it was. Ok it it we have a lot of variation on... on... one day. It might be that this one was done a little bit later, may be an hour later and then you see and blood is not exactly the same hey?
17	**Patient:**	Ok
18	**Doctor A:**	If you take one 5ml, if you take a teaspoon of blood and you take another teaspoon of blood there will be a difference in the CD4 count ok?
19	**Patient:**	Ok
20	**Doctor A:**	It's more or less the same, it is over 200. So to me it's a safe CD4 count alright? We still want it higher but that can take, that can take another year or two even okay?
21	**Patient:**	Yes
22	**Doctor A:**	So I'm, I'm very happy with your CD4 of 271 and I don't think you need to be worried about that okay?
23	**Patient:**	Ok
24	**Doctor A:**	What we still need to do and the Sister took blood today hey?
25	**Patient:**	Yes
26	**Doctor A:**	For... to check the viral load ok. That is where we count the virus. Have you heard of the viral load?
27	**Patient:**	Yes
28	**Doctor A:**	What have you heard about it? You can explain it in Xhosa.
29	**Patient:**	iviral load
30	**Doctor A:**	Uhm
31	**Patient:**	((When you drink your tablets unregular)) the the viral load is down, is up, the virus is up
32	**Doctor A:**	That's right. Ok that's the good answer and it's quite right. Errhm yes, the viral load shows you if the virus is growing in your blood or not. And last time in August it was nice and low. So we will just check that this one is also nice and low, okay?
33	**Patient:**	Yes
34	**Doctor A:**	Sorry, they made a mistake at the lab ok?
35	**Patient:**	Ok
36	**Doctor A:**	Everybody makes mistakes everywhere ((chuckles)). So errh... (0.11) any other problems that you are having?
37	**Patient:**	My eyes
38	**Doctor A:**	How is the ( ), is it itching?
39	**Patient:**	I don't see properly
40	**Doctor A:**	You don't see properly
41	**Patient:**	Yes
42	**Doctor A:**	How long have you had this problem?
43	**Patient:**	Since I started to take ARVs
44	**Doctor A:**	Ok since you started ARVs
45	**Patient:**	Yes
46	**Doctor A:**	Ok what do you mean, what do you mean with not seeing properly?
47	**Patient:**	(0.5)
48	**Doctor A:**	Did it become worse when you started on the ARVs
49	**Patient:**	No
50	**Doctor A:**	No. So was it from before you started on the ARVs
51	**Patient:**	After
52	**Doctor A:**	After
53	**Patient:**	Hmm

54	**Doctor A:**	Can you give me an idea how many weeks..., how many months?
55	**Patient:**	In March
56	**Doctor A:**	March last year. Ok that ok, ok do you want to close your left eye?
57	**Patient:**	Ok
58	**Doctor A:**	Can you see normally in the distance?
59	**Patient:**	(I can see)
60	**Doctor A:**	Can you see how many fingers I'm holding up?
61	**Patient:**	I see three
62	**Doctor A:**	But you are having difficulty to see that
63	**Patient:**	((Three from this side))
64	**Doctor A:**	The other side... okay? How many fingers am I holding up?
65	**Patient:**	(0.5) Four ( )
66	**Doctor A:**	Ok but you did go to to Tygerberg hey, to see the eye specialist?
67	**Patient:**	Hmm yes
68	**Doctor A:**	Okay ok, did they give you a letter Sweety, did they give you a letter?
69	**Patient:**	No
70	**Doctor A:**	NO? (0.7)Would you ask them next time to give us a letter so that we know what is going on?
71	**Patient:**	Hmm
72	**Doctor A:**	Where is your Tygerberg erhm card? Was there no letter attached to that?
73	**Patient:**	No letter attached
74	**Doctor A:**	(0.23) Ok did they explain to you what the problem was in the eyes?
75	**Patient:**	No doctor
76	**Doctor A:**	They didn't explain ((ruffle of paper)) (0.11) Ok I'm just going to see what we have in here. Do you have your Tygerberg number here, Tygerberg card or Tygerberg number?
77	**Patient:**	My card is at home (0.06)
78	**Doctor A:**	Ok I thought your (file was here we could find out) but errh... ok, any other problems that you are having?
79	**Patient:**	No
80	**Doctor A:**	(0.05) ((Let me quickly go and find out))... because they gave you they gave you one tablet for in-in infection in the eye. This is like a tear. If your eye is dry you can use this all the time on it, alright? And this is for discomfort, okay or inflammation this one, okay?
81	**Patient:**	Which is for inflammation?
82	**Doctor A:**	This is for inflammation or discomfort in the eye. This is for infection and you must also complete, complete that one
83	**Patient:**	( )
84	**Doctor A:**	I must quickly go and phone ((opening and shutting of door)) ((door opens and slams shut)) (05.56) Sweety, when did you go to Tygerberg? Which date did you go to Tygerberg?
85	**Patient:**	in Tygerberg I was sleeping in Tygerberg in February neh
86	**Doctor A:**	February this year?
87	**Patient:**	This year
88	**Doctor A:**	Yes?
89	**Patient:**	So the doctor say I must phone then she give me another date for going for Tygerberg
90	**Doctor A:**	For going back?
91	**Patient:**	Hmm
92	**Doctor A:**	Did you phone?

93	**Patient:**	In Hospice, the Sister was going
94	**Doctor A:**	The hospice was going to phone.
95	**Patient:**	Yes
96	**Doctor A:**	Ok but when did you see the eye doctor?
97	**Patient:**	In February
98	**Doctor A:**	When did you sleep there in February?
99	**Patient:**	On the 10th
100	**Doctor A:**	10th February. How many days did you sleep there?
101	**Patient:**	A week, six days
102	**Doctor A:**	Six days ((opening and banging of the door (02.39)) Sweety, your card that you used in Tygerberg, where is that card?
103	**Patient:**	It's at home
104	**Doctor A:**	It's at home?
105	**Patient:**	Yes
106	**Doctor A:**	You must please bring that card because we can't find anything out. I don't know why you were in the Hospital. Was it for the eye?
107	**Patient:**	((On the 7th floor))
108	**Doctor A:**	Uhm yes, but why did you go to hospital?
109	**Nursing Sister:**	You must tell her why did you go to the hospital, *asseblief – please?*
110	**Patient:**	((Addresses Nursing Sister in Xhosa: *unclear*))
111	**Doctor A:**	Alright may be if if, do you have a friend here who can help you with getting your Tygerberg hospital card so that we can find out what the, what the story is? Hmm? How far are you from here?
112	**Patient:**	( )
113	**Doctor A:**	Can you bring that card along next time?
114	**Patient:**	Yes
115	**Doctor A:**	(0.17) because otherwise it's very difficult to find out what they found or anything (0.28) Ok, alright ((ruffle of paper)) I'm repeating all those tablets... and this is your D4t hey?
116	**Patient:**	Yes
117	**Doctor A:**	Ok this one, where are your old tablets let me show you
118	**Patient:**	((rattle of medicine bottles and tablets on the table)) (0.32)
119	**Doctor A:**	I see that ( ). Ok so that is the same hey?
120	**Patient:**	Yes
121	**Doctor A:**	Alright? Ok this one... ooh ((chuckles)) they've changed it alright? This is the same, ok? I'm just gonna I know... I know it's... this is, I know it's confusing. Errhm this one is brown now, okay. I'm just gonna mark it D4t. Can you read it?
122	**Patient:**	Yes
123	**Doctor A:**	Ok D4t (0.15) Ok just take that to Sister B, okay because I want her just I want her to errhm phone about the ( ). (01.07) Oka:y

Appendix 12: Consultation 12

1	**Doctor B:**	Nothing happened when I pressed there. Is it recording now?
2	**Researcher:**	Yes it is recording
3	**Doctor B:**	(0.8) ((Opening and slamming of the door)) Ok Mr D, I am Dr. H. How're you?
4	**Patient:**	Alright and you?
5	**Doctor B:**	According to your file you have to start today. You have to start your treatment today your ARVs, are you ready?
6	**Patient:**	Yes I am more than ready

7	**Doctor B:**	You are ready, you are more than ready.
8	**Patient:**	Uhm
9	**Doctor B:**	Ok what did you discuss at counselling? What did they say about ARVs? What did they teach you?
10	**Patient:**	They said I must be taking them errh accordingly neh?
11	**Doctor B:**	You take them at a certain [time]
12	**Patient:**	[Time] yeah
13	**Doctor B:**	Did they stress the time? What is accordingly?
14	**Patient:**	According to what the what the doctors and the nurses would have told me
15	**Doctor B:**	What did they tell you about time?
16	**Patient:**	If it's in the morning or in the night, I must keep the time.
17	**Doctor B:**	Ok what time have you chosen?
18	**Patient:**	If it is 8.00 o'clock in the morning I must be having always at 8.00 o'clock in the morning. Then if it is 8.00 o'clock in the night I must take the two times
19	**Doctor B:**	What time have you chosen? When are you gonna take your tablets?
20	**Patient:**	8.00 o'clock
21	**Doctor B:**	Eight. So 8.00 in the morning 8.00 in the evening neh, eight forever.
22	**Patient:**	Yeah
23	**Doctor B:**	Eight, at 8.00 o'clock. You only gonna choose once
24	**Patient:**	Yeah
25	**Doctor B:**	But otherwise are you fine?
26	**Patient:**	Yeah, I'm alright except erh here and there I feel headaches, flu and I think that's all
27	**Doctor B:**	What headaches? Have you got a headache?
28	**Patient:**	No it's not continuous, I mean to say like
29	**Doctor B:**	But today [any problem today?
30	**Patient:** [	[No no]
31	**Doctor B:**	Today you are fine
32	**Patient:**	As of today I'm alright
33	**Doctor B:**	You are not coughing or sweating or anything?
34	**Patient:**	No (0.12)
35	**Doctor B:**	Girl friend, Wife? Have you got a girlfriend or a wife?
36	**Patient:**	Wife
37	**Doctor B:**	A wife. Where is she?
38	**Patient:**	At home
39	**Doctor B:**	In ((name of country))?
40	**Patient:**	Here in South Africa
41	**Doctor B:**	Oh ok where? Where?
42	**Patient:**	((name of location)). We stay together
43	**Doctor B:**	In ((name of location))
44	**Patient:**	Yeah
45	**Doctor B:**	Is she also tested?
46	**Patient:**	Yes
47	**Doctor B:**	Is she positive as well?
48	**Patient:**	Sure
49	**Doctor B:**	What is her CD4 count?
50	**Patient:**	Ah it's still alright
51	**Doctor B:**	It's still high. Aah ok so you understand that
52	**Patient:**	Yeah
53	**Doctor B:**	You still have to keep checking after every six months

54	**Patient:**	Yeah
55	**Doctor B:**	Kids, have you got kids?
56	**Patient:**	Yeah
57	**Doctor B:**	How many?
58	**Patient:**	Two
59	**Doctor B:**	Two kids. How old are they?
60	**Patient:**	Seven years and errh nine months almost turning ten
61	**Doctor B:**	Have you tested both of them? Are they fine?
62	**Patient:**	Only one. The other one I've not because he is back home
63	**Doctor B:**	Which one is back home? [The seven years]
64	**Patient:**	[The seven-year-old]
65	**Doctor B:**	You must test her as well eh?
66	**Patient:**	Yes
67	**Doctor B:**	She must be tested. Ok so you're ready neh. You are using condoms at home?
68	**Patient:**	Sure
69	**Doctor B:**	Very important. It's even more important now when you are on treatment because we're gonna reduce your viral load, even though your wife's CD4 count is high your viral load is gonna be lower than hers because yours is gonna be controlled on treatment. So if you don't use a condom she is gonna continue reinfecting you. Six months comes we gonna repeat your viral load and it's gonna be high and we'er gonna tell you, you are not been drinking your tablets and we're gonna fight with that because I can see you are very vigilant.
70	**Patient:**	Ooh Is it?
71	**Doctor B:**	((Chuckles)) We are gonna be fighting with that because we're gonna be telling you something you are not doing. But you understand that condom use is very important. You have kids now and so there is really no reason why. You are finished aren't you or you want more kids?
72	**Patient:**	I want one more
73	**Doctor B:**	Hmm
74	**Patient:**	((chuckles)) Ah that's a joke. I don't want a baby any more. And it's a boy and a girl I am through with that
75	**Doctor B:**	Yeah I thought so
76	**Patient:**	((Chuckles))
77	**Doctor B:**	So you don't cough now at the moment eh?
78	**Patient:**	No
79	**Doctor B:**	((name of location), is it a squatter camp?
80	**Nursing Sister:**	No it's just a name
81	**Patient:**	((Laughs)) Just like ((name of another location))
82	**Doctor B:**	Take a deep breath
83	**Patient:**	((Breathes in and out))
84	**Doctor B:**	Alright so you gonna start today? New commitment neh?
85	**Patient:**	Pardon?
86	**Doctor B:**	New commitment. So you are committed
87	**Patient:**	It's a marriage ((chuckles))
88	**Doctor B:**	It's a second marriage this one.
89	**Patient:**	Yeah, I am going to divorce my wife for the tablets
90	**Doctor B:**	Your wife must help you with this new relationship you've got
91	**Patient:**	Oh we'll be fighting everyday
92	**Doctor B:**	Hmm (0.8) Ok we gonna start. Sister will see you after two weeks and

		I see you after one month. I'm gonna see you on the 29th neh?
93	**Patient:**	Yeah
94	**Doctor B:**	Alright? Any questions?
95	**Patient:**	Any questions? Nothing. You must write for appointment otherwise, *yho* with the kind of jobs that we're doing
96	**Doctor B:**	What do you do?
97	**Patient:**	It's just an ordinary job but the bosses want us to always be at work
98	**Doctor B:**	What are you doing?
99	**Patient:**	Errhm I am a storeman
100	**Doctor B:**	Storeman, where?
101	**Patient:**	At an off sales here in ((name of town))
102	**Doctor B:**	Alright then neh? ((crackle of tablets)) Here is your treatment, keep it safe. Stavudine 8.00 in the morning 8.00 in the evening
103	**Patient:**	EIGHT tablets?
104	**Doctor B:**	8.00 o'clock. One tablet in the morning and one at night. One tablet at night only and one tablet in the morning hmm? This one is only at night. Here one in the morning one at night. You see it is written one at night only. This one is to protect you from pneumonia, two tablets once a day. It's just a form of ant-biotic
105	**Patient:**	Bacterium?
106	**Doctor B:**	Bactrim, yeah. You have been taking this one neh
107	**Patient:**	Yes
108	**Doctor B:**	Alright? So we will see you, I will see you in one month. This one can make you a bit dizzy. Looking a bit drunk
109	**Patient:**	This is why I must take them at night
110	**Doctor B:**	In the night. It's gonna go away. You gonna get used to it neh?
111	**Patient:**	So is it going to last till the following day?
112	**Doctor B:**	It may. Look the first few days can be a bit tough
113	**Nursing Sister:**	Uhmm the first week
114	**Doctor B:**	Yes but you will see yourself. It gets better as time goes on neh? Alright?
115	**Patient:**	*Nkosi*
116	**Doctor B:**	Time is very important, eight o'clock. What time do you go to work?
117	**Patient:**	Errh I can carry them to work
118	**Doctor B:**	Yes you can. But at what time do you get to work? Are you at work at 8.00 o'clock?
119	**Patient:**	Yeah
120	**Doctor B:**	At Clicks neh they have small pill containers, small ones small pill containers that you can always carry in your pocket then you don't have to carry all of this around.
121	**Patient:**	Yes
122	**Doctor B:**	Yeah, so get a pills container at Clicks, the smaller ones for...and you must always have the next three doses with you
123	**Patient:**	Ok, in case I don't get home. Thank you. Where must I get them? ((Do I hold like this one))? Do I have to carry with the envelop? I'll put it in my pocket. You can keep it for the next person. I think I can start tomorrow morning ((addresses Nursing sister in Xhosa))
124	**Nursing Sister:**	((Responds in Xhosa))
125	**Doctor B:**	That's what I was thinking too. Mr. D bye-bye eh?
126	**Patient:**	Bye-bye

Appendix 13: Consultation 13

1	**Doctor B:**	Ok N, how are you?
2	**Patient:**	Fine
3	**Doctor B:**	Do you speak English?
4	**Patient:**	Yeah
5	**Doctor B:**	So we have to speak English now
6	**Patient:**	Yeah
7	**Doctor B:**	When did they diagnose you with HIV?
8	**Patient:**	Uh:m in February
9	**Doctor B:**	In February neh? You are not on TB treatment at the moment neh?
10	**Patient:**	No
11	**Doctor B:**	No ok but I see here they didn't order your errh treatment, so today we can't start today. We'll have to first order your treatment and you will come after two weeks to start treatment
12	**Patient:**	Ok
13	**Doctor B:**	Ok otherwise how are you doing?
14	**Patient:**	I'm ok
15	**Doctor B:**	You are alright. How old are you now?
16	**Patient:**	I'm 28
17	**Doctor B:**	28, have you got kids?
18	**Patient:**	Yeah one
19	**Doctor B:**	How many?
20	**Patient:**	One
21	**Doctor B:**	How old?
22	**Patient:**	Six
23	**Doctor B:**	Did you test him?
24	**Patient:**	Yeah
25	**Doctor B:**	Is he positive?
26	**Patient:**	No
27	**Doctor B:**	Negative ok. New boyfriend? Have you got a boyfriend?
28	**Patient:**	No I am living alone
29	**Doctor B:**	You are living alone at the moment?
30	**Patient:**	Yeah
31	**Doctor B:**	Ok alright. Any problems today?
32	**Patient:**	Oh no
33	**Doctor B:**	Hmm (0.7) So today we are just going to examine you to make sure that everything is fine, order your new treatment and in two weeks you can come and start your treatment neh?
34	**Patient:**	Ok
35	**Doctor B:**	So just lie down there on the bed (0.30) Are you shy?
36	**Patient:**	((Chuckles))
37	**Doctor B:**	You look shy. Don't be shy neh?
38	**Patient:**	Ok
39	**Doctor B:**	(0.21) So err::hm everything looks fine neh? We're gonna order the treatment today and in two weeks time you can come and start neh?
40	**Patient:**	Ok
41	**Doctor B:**	Alright, have you got any questions?
42	**Patient:**	No
43	**Doctor B:**	((Opening and closing of door, flipping of paper)) (0.30). Do you still want children?
44	**Patient:**	No
45	**Doctor B:**	You don't want children?

46	**Patient:**	No
47	**Doctor B:**	Are you sure?
48	**Patient:**	Positive
49	**Doctor B:**	Are you positive about it? Are you sure?
50	**Patient:**	Yeah
51	**Doctor B:**	But you are only 28years old
52	**Patient:**	((Chuckles))
53	**Doctor B:**	If you found somebody that you you really like...who loves and marries you and wants children, would you consider it?
54	**Patient:**	May be
55	**Doctor B:**	May be. So you you it's not completely 'no, no' neh? Ok so that influences our choice of your treatment eh?
56	**Patient:**	Ok
57	**Doctor B:**	So we have to give her Nevirapine. She is angry now she still feels sick. Once she feels healthy then she will act like normal 28-year olds
58	**Patient:**	((Chuckles))
59	**Doctor B:**	You are not allergic neh to any treatment?
60	**Patient:**	No
61	**Doctor B:**	(0.08)
62	**Nursing Sister:**	( ) ((daily dose))
63	**Doctor B:**	It's once daily. The the patients on Nevirapine don't really benefit that much from it, I mean in terms of convenience of dosaging you know. We literally are giving it here for errh errh Hepatitis. But the guys with Stocrin actually benefit because their regime moves from being a two-times-a-day regime to once a day dosage. ((So those make a big killing)), but then the people with Nevirapine unfortunately still have to carry on with the Nevirapine twice a day and as a result you don't give them the 3TC 300 solid one. We carry on with the 150bd
64	**Nursing Sister:**	( )
65	**Doctor B:**	The once a day is not really... you see it's... it's
66	**Nursing Sister:**	( )
67	**Doctor B:**	Yes remember it's 3TC is 150 bd which is 300 per day. But there is a special formulation. The 3TC once a day doesn't look like that. So you can't just give it, it's a special sort of a slow release formulation to make it convenient. She is not gonna get that one. She will get the normal 150 bd, neh. (To the patient) We are just talking about what, why we're choosing the treatment we are giving you. The other thing is you've got another viral infection of the liver. I don't know if they told you, you have a Hepatitis B virus infection eh? So we err we have to give you special treatment so that we can cover that as well?
68	**Patient:**	Ok
69	**Doctor B:**	Neh? So you are not gonna be on the normal treatment that everybody gets. One of your tablets is a special one
70	**Patient:**	Ok
71	**Doctor B:**	It's only people who have Hepatitis B who get it Ok? Alright, are you happy?
72	**Patient**:	Yeah
73	**Doctor B:**	Ok alright you will come in two weeks time
74	**Patient:**	Ok
75	**Doctor B:**	Alright, bye bye

Appendix 14: Consultation 14

1	**Doctor C:**	Did she
2	**Patient:**	Yes she explained to me
3	**Doctor C:**	Listen, I'm tomorrow in ((name of town)), not not in ((name of another town0) again.
4	**Researcher:**	Wh-where in ((name of town))? In in
5	**Doctor C:**	((Name of facility)). Do you want to see me in there?
6	**Researcher:**	Yes doctor, I will.
7	**Doctor C:**	Ok we can do that
8	**Researcher:**	Ok Doctor I'm outside
9	**Doctor C:**	Ok thanks. Ok this is just, we will just ignore this
10	**Patient:**	Ok ok no problem
11	**Doctor C:**	because what's happening is they are trying to evaluate my English
12	**Patient:**	Okay
13	**Doctor C:**	So they want to see it's great to talk to you through somebody but sometimes I want to talk to people and a lot of people can't speak English. I am also, Afrikaans is my first language
14	**Patient:**	Hmm
15	**Doctor C:**	So my second language is [English]
16	**Patient:**	[English] hmm
17	**Doctor C:**	And I think we need to communicate in English. So why...what they're checking is they check if I am using the English correct and how they can change that
18	**Patient:**	Ok
19	**Doctor C:**	Anyway how are you Miss P?
20	**Patient:**	Doctor it's I'm fine. I'm not fine
21	**Doctor C:**	Y:e:s?
22	**Patient:**	First thing it's MY SKIN. I have a SKIN PROBLEM
23	**Doctor C:**	Uhmm
24	**Patient:**	I don't know what is the problem, from December I've got these pimples
25	**Doctor C:**	And that's new, you haven't had them before
26	**Patient:**	No and they were BAD
27	**Doctor C:**	Is it, is it?
28	**Patient:**	Yes but now they are much better because Sister M gave me errhm Acqueous cream
29	**Doctor C:**	Hmm
30	**Patient:**	I wash myself with acqueous cream and I smell acqueous cream but they don't go away?
31	**Doctor C:**	Do you still see new ones?
32	**Patient:**	Yes like this one
33	**Doctor C:**	There are still new ones?
34	**Patient:**	Y:E:E:S
35	**Doctor C:**	I just want to see.
36	**Patient:**	Like these ones
37	**Doctor C:**	And then is there pus in it, is that white stuff in it?
38	**Patient:**	Nno
39	**Doctor C:**	Is it? Hmm, hmm.
40	**Patient:**	Hmm they are sore
41	**Doctor C:**	Yeah but you don't like the colour, they change your face. You are like a teenager again.
42	**Patient:**	No

43	**Doctor C:**	You don't want to be teenager again?
44	**Patient:**	No::, doctor but they spoil my face
45	**Doctor C:**	Yes yes.
46	**Patient:**	I don't want to look like this
47	**Doctor C:**	You don't want to look like this
48	**Patient:**	No doctor
49	**Doctor C:**	Ok ok so I just want to write down [the skin
50	**Patient:**	[And the other thing
51	**Doctor C:**	Y:e:s?
52	**Patient:**	My feet
53	**Doctor C:**	Hmm
54	**Patient:**	Every morning it's sore, they are sore.
55	**Doctor C:**	Is it like pins and needles?
56	**Patient:**	Yes every morning when I wake up
57	**Doctor C:**	Is it?
58	**Patient:**	Yes
59	**Doctor C:**	Uhmm and you had that before or are it's getting worse now?
60	**Patient:**	It's getting worse.
61	**Doctor C:**	Is it?
62	**Patient:**	Sister M was giving me pills but they DON'T HELP me
63	**Doctor C:**	Is it? They've explained to you where it comes from, hey?
64	**Patient:**	Yes
65	**Doctor C:**	It's the small nerves in the feet that get damaged and things like that
66	**Patient:**	Hmm
67	**Doctor C:**	And there are a lot of things that can damage it. It can be the nerves ah, it can be the medication and it can be the virus itself
68	**Patient:**	Hmm
69	**Doctor C:**	It can be that we don't have enough vitamins and things like that
70	**Patient:**	Hmm
71	**Doctor C:**	But usually it gets better after a while and things like that. So I would worry if it's not getting [better]
72	**Patient:**	[It's] now a long time
73	**Doctor C:**	Is it? Ok errhm
74	**Patient:**	The MAI::N PROBLEM
75	**Doctor C:**	Yes?
76	**Patient:**	I haven't seen...but I am not pregnant. I haven't seen my period for I think it's about five or six months now, and I did pregnancy test here last year I think it was December or January. But I'm sure I am not pregnant.
77	**Doctor C:**	Hmm
78	**Patient:**	So that's what I wanted the doctor to check whether it's the change of life or what is it [because I am
79	**Doctor C:**	[How old are you?
80	**Patient:**	I'm reaching forty next week
81	**Doctor C:**	Oh you are going to be forty next week
82	**Patient:**	Yes
83	**Doctor C:**	Ok ok
84	**Patient:**	May be it's menopause I don't know
85	**Doctor C:**	Yeah, well, people can have menopause at at forty at forty but err we need to check and the other thing that happens is sometimes when people get sick, very sick, they also have a problem. They can also stop menstruating. It's the body you know, some people that have

		lost weight. We see a lot of people with HIV just because they are sick they are missing [their...
86	**Patient:**	[Hmm
87	**Doctor C:**	What prevention did you use previously?
88	**Patient:**	Ner-r-r
89	**Doctor C:**	Nerestrait. Are you still using that?
90	**Patient:**	No::
91	**Doctor C:**	[You are only using condoms only]
92	**Patient:**	[I stopped on December] condoms only
93	**Doctor C:**	When you used Nerestrait you still had periods or not?
94	**Patient:**	No
95	**Doctor C:**	OK. So when last did you had a period?
96	**Patient:**	I think December late last year
97	**Doctor C:**	Late but when you were on the Nerestrait you still had a period or not?
98	**Patient:**	No
99	**Doctor C:**	No, no
100	**Patient:**	I stopped Nerestrait, I saw my periods
101	**Doctor C:**	Once?
102	**Patient:**	and then they stopped doctor
103	**Doctor C:**	Ok. OKAY so we need to look at your skin, we need to look at your feet that's painful and we are going to look why you are not getting your period
104	**Patient:**	Yes doctor, please
105	**Doctor C:**	And you are now on treatment for one year neh?
106	**Patient:**	Yes doctor
107	**Doctor C:**	Did Sister M discuss your viral load with you?
108	**Patient:**	No::
109	**Doctor C:**	And your CD4?
110	**Patient:**	Yes with my CD4 count
111	**Doctor C:**	Yeah, yeah
112	**Patient:**	She did tell me about my CD4 count, it's a little bit
113	**Doctor C:**	Good and things
114	**Patient:**	Yes ((opening of door))
115	**Doctor C:**	Sorry Sister
116	**Nursing Sister:**	Ehmm doctor, H is from IDC on antiviral drugs
117	**Doctor C:**	Yeah?
118	**Nursing Sister:**	( )
119	**Doctor C:**	Ok. Is it is it, did they have the err just ask Sister to give us from which IDC
120	**Patient:**	Your ((name of town)) TC Newman
121	**Doctor C:**	TC ok. You can just put it in the (name of town)) TC ok?
122	**Nursing Sister:**	Thank you doctor
123	**Doctor C:**	Ok errhm ((bang of door))
124	**Patient:**	Yes she told me my CD4 count is 344
125	**Doctor C:**	That's great and the viral load?
126	**Patient:**	She didn't tell me about the viral load
127	**Doctor C:**	The viral load is beyond detectable levels
128	**Patient:**	Why?
129	**Doctor C:**	How do you understand that? Do you understand that?
130	**Patient:**	That is the problem. I know my CD4 count but the viral load I don't understand about the viral load

131	**Doctor C:**	Ok I'm going to try to explain to you
132	**Patient:**	Yes please
133	**Doctor C:**	We take some of your blood ok?
134	**Patient:**	Hmm
135	**Doctor C:**	And then we take some of the blood and we take one drop of blood and then we put it and we take a photo of it and in that photo we can see how many of the good CD4s is in your blood
136	**Patient:**	Ok
137	**Doctor C:**	It's like when you are taking a photo of the township?
138	**Patient:**	Uhmm, uhmm
139	**Doctor C:**	Then you would see what's happening on the streets.
140	**Patient:**	Uhmm
141	**Doctor C:**	In this streets you would see all of these good people going to work
142	**Patient:**	Uhmm
143	**Doctor C:**	And they are doing fine
144	**Patient:**	Uhmm
145	**Doctor C:**	That's the CD4s. Now if everything is good in the town there would be a lot of people going to work. But if there is a lot of *skollies* in the road they will start killing and chasing the good people away
146	**Patient:**	Of course
147	**Doctor C:**	Now what we do is when we take the photo we see how many of the good people is there and we also see how many of the viruses are there
148	**Patient:**	Ok
149	**Doctor C:**	Now if we say it is lower than detectable it means that on this photo that we have taken we don't see any viruses.
150	**Patient:**	Ok
151	**Doctor C:**	So that means that the medication is killing all the viruses in your blood
152	**Patient:**	Is it?
153	**Doctor C:**	So it is important to remember that the medication is not taking the virus out of your body but it is taking the virus out of your blood
154	**Patient:**	Ok
155	**Doctor C:**	So you drink the medication and it goes into your stomach, it goes into the liver, then it goes to your err errhm errhm, then it goes into your
156	**Patient:**	Yeah, your system *mos*
157	**Nursing Sister:**	((explains in Afrikaans))
158	**Patient:**	Yeah, man
159	**Nursing Sister:**	((Continues in Afrikaans))
160	**Patient:**	*Nee* Sister.((laughs))
161	**Nursing Sister:**	((laughs))
162	**Doctor C:**	Is it? Ok fine. Errhm so that's how the viral …so what happens then it gets into your blood
163	**Patient:**	Y:e:s
164	**Doctor C:**	and then in your blood
165	**Patient:**	Y:e:s
166	**Doctor C:**	it errhm you know, the medication kills all the viruses
167	**Patient:**	Uhhm
168	**Doctor C:**	But there is a lot of viruses in the rest of your body
169	**Patient:**	Y:e:s

170	**Doctor C:**	like in your glands. So every morning there are new viruses so you need to use the medication again and every evening there is new virus and so you need to use
171	**Patient:**	Ok
172	**Doctor C:**	So we are very happy, my job is done
173	**Patient:**	Ok
174	**Doctor C:**	Your virus is under control and things like that
175	**Patient:**	Ok thank you ((laughs))
176	**Doctor C:**	So we are happy with that and things. My only problem is that are we going to get your skin better or not?
177	**Patient:**	That's my problem, that's my MAIN problem doctor
178	**Doctor C:**	Now is your skin linked to the fact that you don't get your periods?
179	**Patient:**	I think so, I think so
180	**Doctor C:**	I don't think it's the medication causing the skin problem. I think it's the normal 'getting older' that is [causing the problem]
181	**Patient:**	[O::oh ((laughs))] don't say that doctor
182	**Doctor C:**	Yeah so we don't know. It can be the menstruation agh it can be due to the injection. Sometimes it takes more than a year to get back...
183	**Patient:**	MORE THAN A YEAR?
184	**Doctor C:**	to get your periods back
185	**Patient:**	Is it?
186	**Doctor C:**	yeah so that's the two things that I'm not sure about
187	**Patient:**	So there is nothing you can give me to get my periods back?
188	**Doctor C:**	No, we'll just need to wait
189	**Patient:**	So my face will be like this for a YEAR?
190	**Doctor C:**	((chuckles)) I don't know
191	**Patient:**	((chuckles)) Ok
192	**Doctor C:**	And then we just need to see Sister. I've given you something for the, for the (to rub there) I've given you some treatment for that, did that help a bit?
193	**Patient:**	((Screeching of door)) It didn't. What was it, Biocort it didn't help
194	**Nursing Sister:**	(speaks in Afrikaans)
195	**Doctor C:**	[((laughs))]
196	**Patient:**	[((Chuckles))] What about the the Topivate, that helped me
197	**Doctor C:**	Yeah, we don't want to put too many steroids on your skin because then your skin gets thin and thin like that
198	**Patient:**	And my skin is too sensitive
199	**Doctor C:**	Uhhm if we don't get, if say it doesn't get a bit better, if you're not feeling better I need to refer you to a skin specialist. There's one in ((name of facility)) but they are quite fully booked and things like that
200	**Patient:**	Is it?
201	**Doctor C:**	But we will try that and see if they have ((some advice))
202	**Patient:**	Ok
203	**Doctor C:**	But I'm very happy your HIV is doing fine, your weight is good, I'm happy about that. That's good things
204	**Patient:**	Thank you doctor
205	**Doctor C:**	Ok ((chuckles))
206	**Patient:**	((Chuckles))
207	**Doctor C:**	This is ( )(0.17)
208	**Patient:**	And these headaches, is this because of the high blood pressure?
209	**Doctor C:**	Uhhm yeah, well

210	**Patient:**	I am a high blood patient
211	**Doctor C:**	The blood pressure is 120/90 today so it's
212	**Patient:**	It's ok
213	**Doctor C:**	It's ok, errhm yeah some people just think it's... ( ) but it is not always the high blood but it can be. How is the rest of your life? You are not stressed and things like that
214	**Patient:**	Oh I am sometimes
215	**Doctor C:**	Is it, is it? Like all of us
216	**Patient:**	((Chuckles)) Children, children
217	**Doctor C:**	Children ((chuckles)) Errhm no signs of TB hey?
218	**Patient:**	No
219	**Doctor C:**	(0.10) If you have pains on your feet do you use any do you use any pain tablets or anything for that?
220	**Patient:**	Sister M did give me some tablets
221	**Doctor C:**	Did that... yeah
222	**Patient:**	They didn't help me
223	**Doctor C:**	Is it? Ok so we will check your menstruation for the rest of the month
224	**Patient:**	Ok, ok
225	**Doctor C:**	(0.08) When last did you have a pap smear?
226	**Patient:**	Sometime last year
227	**Doctor C:**	Ok and that was normal, ney?
228	**Patient:**	Yes, doctor
229	**Doctor C:**	(0.23) Ok let's see if I can get your medication (0.7). What are you going to do for Easter, are you going away somewhere?
230	**Patient:**	No
231	**Doctor C:**	Is it?
232	**Patient:**	I'm going to church
233	**Doctor C:**	Is it? So do you also believe in fish and all those things?
234	**Patient:**	Y::e::s curry fish
235	**Doctor C:**	Curry fish and things
236	**Patient:**	Yes, doctor ((chuckle))
237	**Doctor C:**	Let's see what Sister has here. So that's your ARVs, you know them
238	**Patient:**	The other thing I want to ask doctor is why am I using ARVs when I am not pregnant?
239	**Doctor C:**	Nevirapine?
240	**Patient:**	Nevirapines are not for people who are pregnant
241	**Doctor C:**	No, ok Nevirapine you can use with everybody ok
242	**Patient:**	Okay
243	**Doctor C:**	but Stocrin you can't use with people that's that's pregnant
244	**Patient:**	Hmm
245	**Doctor C:**	Stocrin is also the one you use when you have TB
246	**Patient:**	Oooh
247	**Doctor C:**	But if you don't have TB you can use the Nevirapine
248	**Patient:**	Okay
249	**Doctor C:**	So it's not something
250	**Patient:**	Ok
251	**Doctor C:**	So that's your blood pressure tablets
252	**Patient:**	Why are they giving me these? I'm taking these from ((Name of facility)). I have them
253	**Doctor C:**	You have enough of them?
254	**Patient:**	Yes I have enough of them at home
255	**Doctor C:**	So we can leave this and this out. Let's see what else is there. This is

		like a lucky package hey?
256	**Patient:**	Oh no. Those are all the high blood
257	**Doctor C:**	This is not the high blood one. This is for the feet but it makes [the feet]
258	**Patient:**	[For the feet] but they don't help me
259	**Doctor C:**	But you can actually take two or three at night but it will make you a bit of sleepy
260	**Patient:**	Yes, that's something I noticed
261	**Doctor C:**	and it will make your mouth dry
262	**Patient:**	In the morning also you feel dizzy
263	**Doctor C:**	Ok and this is your vitamin BCo
264	**Patient:**	Must I drink them again? Sister M said that I must not drink again because my CD4 is high
265	**Doctor C:**	Hmm it's not really a problem but may be with your feet it's a good idea to carry on with it
266	**Patient:**	Ok thank you doctor. But this I needed this one
267	**Doctor C:**	You wanted this one?
268	**Patient:**	Yes please
269	**Doctor C:**	And this is your three high [blood one]
270	**Patient:**	[I have a lot of them at home]
271	**Doctor C:**	I just have to take them off our list
272	**Patient:**	Thank you::
273	**Doctor C:**	((And then they don't want to do that)) uuhm and you keep the Dispirin and this one ok?
274	**Patient:**	Yes doctor
275	**Doctor C:**	Great, nice to see you. Nice to have I'm so glad your viral load is doing good
276	**Patient:**	Me too doctor
277	**Doctor C:**	So I need to give you still a date…
278	**Patient:**	My card.
279	**Doctor C:**	for next month you can only see Sister hey?
280	**Patient:**	Yes doctor thank you::
281	**Doctor C:**	Which church are you going to?
282	**Patient:**	URC (Enkierke)
283	**Doctor C:**	((chuckles)) (Enkierke)? Ok man, ok nice meeting you and thanks for the recording
284	**Patient:**	Thank you doctor bye
285	**Doctor C:**	Bye

Appendix 15: Consultation 15

1	**Doctor C:**	((opening and closing of door)) Hello? Do you want a chair?
2	**Patient 1:**	Sorry?
3	**Doctor C:**	Do you want a chair?
4	**Patient 1:**	Yeah
5	**Doctor C:**	Can you get a chair? Then you sit (0.31) ((opening and banging of door)) Errhm, ok, I'm Dr. G, Dr. rrrhm what's the name? Dr. P is on leave so I'm helping you today and things like that. Thanks for coming. Do you speak English?
6	**Patient 2:**	Yes
7	**Doctor C:**	Is it? We're going to ignore this recording. This is just something to where they help me speak English to patients because my first

language is Afrikaans. So I would like to talk to people in their own language, agh in well I can't speak Xhosa so I would like to use English but we see if we can use it better. How are you feeling today?

Patient 2: I am feeling better

Doctor C: You are feeling better?

Patient 2: Yeah

Doctor C: And you are coming today for your treatment is that right or do you come in for results? Or what did doctor decide last month last week?

Patient 2: She said I was supposed to come get errh the treatment

Doctor C: For treatment. Ok I just want to check. I'm sure your treatment is here ((squeaking sound)) yes, but before we start the treatment I just want to make sure that we have everything in place and everything right and things like that. Now errhm, according to doctor you've been always strong you didn't have any problems before. You have never been in hospital is that true? You've never had any operations

Patient 2: No

Doctor C: Nothing like that and no operations before... and how old are you?

Patient 2: 26

Doctor C: 26 and you have two children

Patient 2: Yeah

Doctor C: And this is your husband?

Patient 2: Yes

Doctor C: Is it? Oh ok. Are you on treatment or not?

Patient 1: I am on treatment

Doctor C: You are under ARVs?

Patient 1: Yes

Doctor C: Is it? When did you start?

Patient 1: In March, in March last month

Doctor C: Last month, ok and how was your first month, are you coping?

Patient 1: *Yho*! This month I was feeling so:: dizzy

Doctor C: Is it? But you are feeling better

Patient 1: In fact that tablet for later?

Doctor C: Yeah the evening one is a problem

Patient 1: Yes but now it's better

Doctor C: Is it? Do you think it's gonna go easier with you? ((To Patient 2)) You women are stronger than men?

Patient 2: ((Chuckle))

Doctor C: ((Ok in March)). That's fine, that's fine. Ok so you discovered the HIV in 2007, so that is two years ago neh? So since then up till now what happened? Did you see anything different in your body?

Patient 2: I lose the weight

Doctor C: You lose weight, quite a lot? Were you fat?

Patient 2: Yeah

Patient 1: She was fat

Doctor C: Is it? Ok. We know that when there is HIV in your blood it uses a lot of your energy because remember in one person with HIV there is as many viruses in the body as there are people on the earth. So they take all your energy and sometimes people lose a lot of weight. The other thing why people lose weight is with HIV is that they need to be careful that they don't develop TB. So we also need to check the TB. There are two reasons why people lose weight that is, the viruses are many of them they use a lot of energy and the other thing is that

		when you have TB is another reason. But I've not seen any TB on you; I haven't picked up any TB on you. You never had TB before
41	**Patient 2:**	((negation sound))
42	**Patient 1:**	Errh doctor sorry, she is waiting for the result of coughing
43	**Doctor C:**	Is it?
44	**Patient 1:**	Yeah but she was make a chart to her ( ) but in that chart they said to me she has no TB.
45	**Doctor C:**	Uhmm
46	**Patient 1:**	But again they took this
47	**Doctor C:**	Sputum
48	**Patient 1:**	sputum and then they said she must wait for, that she must come to take results
49	**Doctor C:**	Uhmm yeah, we'll check for that ok. Remember there is something we need to remember about HIV and TB. HIV is in your blood and I can take your blood to see if there is HIV so HIV is easy to see. TB is very difficult. TB is clever. It is not in your blood but in your lungs, in your glands and it is sometimes difficult to see if somebody has TB. Sometimes you need to listen to, do the person cough a lot? Do they have a lot of err err night sweats? Do they lose weight? Do they feel weak and things? So with TB we sometimes you still have to listen is there any of those symptoms. So did you notice any of those in your body? Do you sweat a lot at night? Do you cough a lot?
50	**Patient 2:**	No but the problem is the ears. When I am talking my ears is closed
51	**Doctor C:**	Is it? So you have a problem with your ears
52	**Patient 2:**	Yes
53	**Nursing Sister:**	((opening and banging of door)) ((speaks in Afrikaans))
54	**Doctor C:**	Uhm ((speaks in Afrikaans)). Yeah((chuckles))You are not going to get paid for that.((ruffle of paper)) Errhm I am just checking your results errm CD4 is 41 ok, errm you've lost weight. Any problems with your skin? No problems with your skin just the ear problems.
55	**Patient 2:**	No
56	**Doctor C:**	Sores in your mouth? Nothing like that?
57	**Patient 1:**	But she just doesn't want to eat food
58	**Doctor C:**	Is it, you don't feel like eating?
59	**Patient 1:**	(Even drink she doesn't drink like us)
60	**Doctor C:**	Is it? The stomach is not running?
61	**Patient 2:**	((negation sound))
62	**Doctor C:**	Did you ever have sores in your mouth? Just open your mouth (0.10) ok, so doctor I just want to see got some bloods on you last week to see what's going on with you. Errm one of the things they have done is to test and see is your liver strong enough and we see you have good liver and if your liver is strong enough you can take the medication and I am happy with that. Errh we have looked at your errhm Hepatitis that's a test to see if there is infection in your liver, that's good. We have looked in your blood to see if there is any of what we call ((decrypcucal meningitis)) but we didn't see any of that. But what we see in your blood is that we have different parts of bloods, the white cells; they are the group that protect the body, ok?
63	**Patient 1:**	Ok
64	**Doctor C:**	But then we also have the red cells and the red blood cells are the ones that carrying oxygen
65	**Patient 1:**	Yes

66	**Doctor C:**	And if you don't have enough red blood cells you can feel weak and tired and you can even feel sometimes that you get dizzy and things like that. Now normal count you would have 10 and more ♌***but you only have 5.5. So we have ↓a low low red cells in your body↓*** Now we also checked that the reason for low red cells sometimes can be because you have ↓low low errhm iron and things like that↓. So we are still waiting for those iron tests to come back and things like that. Now what is important is if we see your ((clumstasis)) alone we need to consider giving [you blood ok? But I think we can actually start treatment and see if your body gets better ok?]
67	**Nursing Sister:**	[((opens and closes door)) Sixth of May]
68	**Patient 1:**	Yeah
69	**Doctor C:**	What do you think? You're ready to start?((opening and closing of door))
70	**Patient 2:**	***Yeah***
71	**Doctor C:**	(0.50) ((ruffle of paper)) You have lost a lot of blood. Have you been bleeding a lot or not?
72	**Patient 1:**	Yes she was bleeding a lot of blood ()
73	**Doctor C:**	Was it your periods or when were you…?
74	**Patient 2:**	Yeah
75	**Doctor C:**	Is it, you lost a lot of blood?
76	**Patient 2:**	[Yeah]
77	**Patient 1:**	[Yes]
78	**Doctor C:**	Are you still losing a lot of blood?
79	**Patient 2:**	No
80	**Doctor C:**	Were you pregnant or what happened? Or was it just…why did you lose blood?
81	**Patient 1:**	She was not pregnant but sometimes I think she would make a month or what,'cos she can stay a long time and is not a problem but...
82	**Doctor C:**	then she gets a lot of period
83	**Patient 1:**	Yeah, yeah
84	**Doctor C:**	When last did you have a period?
85	**Patient 2:**	This month
86	**Doctor C:**	Because it looks like it's because you've lost blood that you have a low HB ok, because the rest of your blood looks fine. Sometimes people can have a low red blood cells because the body is a bit too lazy to make blood but your body don't look lazy. It is actually making good blood and things like that so errhm (0.05), let's just see, errhm that is one of the reasons. So we need to see so if you get bad periods and things and it carries on we need to give you blood at some stage ok? Did doctor give you iron last month or last time?
87	**Patient 1:**	[Yes]
88	**Patient 2:**	[Yes]
89	**Doctor C:**	(0.18) ((ruffle of paper) Errhm when you were pregnant you didn't have ARVs or did you? Did they give you treatment when you were pregnant for your children the last one 2007? Did they give you AZT?
90	**Patient 1:**	[Yeah]
91	**Patient 2:**	[Yeah]
92	**Doctor C:**	The baby is negative neh?
93	**Patient 1:**	[Yeah]
94	**Patient 2:**	[Yeah]

95	**Doctor C:**	(0.8) 2007, so the baby is now three years-two years?
96	**Patient 2:**	Yes
97	**Doctor C:**	Is it? ((chuckle)) (0.24) Do you plan more children?
98	**Patient 1:**	Nope
99	**Doctor C:**	((chuckles)) Are you sure are you planning more children?
100	**Patient 2:**	((Mh-mh))
101	**Doctor C:**	Not now, may be one day. Ok ((ruffle of paper)) ok I'm going to show you your treatment. Ok so this, you know this is your Bactrim, and this is your BCo and you must carry on with your iron and things like that ok?
102	**Patient 2:**	Yes
103	**Doctor C:**	And now, this one is the combination of ARVs, ok? So they are like a team, they work together. They are like a rugby or soccer team. You can't play without this one you need to play with all of them together ok?
104	**Patient 2:**	((chuckles))
105	**Doctor C:**	So that is the first rule. If one of them gets lost you must come back and get the rest of them ok? So this one, you're going to take one in the morning one at night, the both of them.
106	**Patient 2:**	Ok
107	**Doctor C:**	This is the strong medication that goes through your liver, ok? We call them the Nevirapine, ok? And your body first needs to be used to them before we're going to give you the full dose ok? For the first two weeks you are only going to take one of them a day and then I'm going to take blood from you after two weeks to make sure your liver is strong enough and then we will increase them.
108	**Patient 1:**	This one you take four?
109	**Doctor C:**	No, no [One]
110	**Patient 1:**	[One]
111	**Doctor C:**	Ok you can, yeah; you one a day and then you see immediately if you are ok then you will increase it. Now you need to remember this is strong treatment and you do have a low HB so if you have problems you must come back to me early. If you run into big problems and you feel very weak you must go to the hospital, take this medicine with you and you tell them, my HB is low. Show them your hands so that they can give you blood, ok? We don't want to give everybody blood but if we can give blood like that when it is necessary, when you run into trouble don't be afraid to go to the hospital. Is that ok? Are you ready?
112	**Patient 2:**	Yeah, I'm ready
113	**Doctor C:**	Any questions?
114	**Patient 2:**	°°°I have no questions°°°
115	**Doctor C:**	Is it? Are you going away for Easter or you're going to stay around?
116	**Patient 2:**	Ah I'm staying around
117	**Patient 1:**	((We are staying around because we have no money))
118	**Doctor C:**	Oh boy, yeah. Are you working at the moment or not?
119	**Patient 1:**	No I'm not working. I think they were give me a grant for there to the ((name of facility)) from October to September
120	**Doctor C:**	Uhmm
121	**Patient 1:**	There I was given a folder and they said to me to go to the ((name of clinic))
122	**Doctor C:**	Yes

123	**Patient 1:**	then I was get a grant for one year
124	**Doctor C:**	Uhumm
125	**Patient 1:**	So it's gonna finish in August
126	**Doctor C:**	Ok
127	**Patient 1:**	Now we are waiting for the 16th and 16 is not here. So we are gonna stay here. We are going nowhere
128	**Doctor C:**	Ok so the 16th you would get the grant money
129	**Patient 1:**	Yeah
130	**Doctor C:**	Ok, ok so you will get that going. Ok I just want to fill in all this stuff. So your starting day is today, is the 9th. What was your weight today, did they write it down somewhere? ((Flipping of papers)) (0.32) Errh you feeling weak, you are feeling weak hey?
131	**Patient 2:**	Yes
132	**Doctor C:**	And you have the ear problem neh?
133	**Patient 2:**	Yes
134	**Doctor C:**	And the vomiting and diarrhea is better neh? No vomiting (0.35) You know what's the problem in two weeks' time, there is the election. You just need to check with Sister what we are going to do then, which day because remember in two weeks from now is the 22nd then everybody is voting. So we just need to see, I will like to or somebody needs to see you at that stage we'll just discuss it with Sister
135	**Patient 1:**	Alright doctor
136	**Doctor C:**	Ok
137	**Patient 1:**	((I have problem of feet))
138	**Doctor C:**	Is it, the feet are sore?
139	**Patient 1:**	They feel pain and they feel cold. So if I'm walking, if I'm walking a long distance
140	**Doctor C:**	Yes, driving?
141	**Patient 1:**	No, walking with my foot
142	**Doctor C:**	Oh you walk a long distance, yes?
143	**Patient 1:**	Yes, so I feel so tired in my feet. ((The only thing is that I don't know what the problem is))
144	**Doctor C:**	Yeah I think what we need to remember is that errhm, what is IMPORTANT to remember is that it takes some time to get the viruses down. So as the viruses get down the body gets better. So unfortunately it will take some time but it will get better

Appendix 16: Consultation 16

1	**Doctor C:**	((laughs)) Errh we can't, we're just going to ignore this
2	**Patient:**	Ok
3	**Doctor C:**	Errh we are going on like always and see what we can do and things. How are you?
4	**Patient:**	I'm fine, I'm well
5	**Doctor C:**	Is it? You're well?
6	**Patient:**	Yeah but last month they say my weight is down then they take the blood for my CD4 count, then I am supposed to get the results today
7	**Doctor C:**	So you are anxious about that hey? The previous one in September was 555. That was still good so I need to look for the results
8	**Patient:**	Yeah
9	**Doctor C:**	But luckily your weight looks better today

Patient: Uhumm I see
Doctor C: What was the reason for your weight loss, do you know?
Patient: Errh I don't know but the other thing they say they made a mistake and gave me too much tablets and I get more than, more tablets.
Doctor C: Is it?
Patient: Yes, errh the other thing I'm not eating too much, may be is the other thing
Doctor C: Is it? Do you want to, is it a problem that you don't want to eat or is it a problem that you don't feel like eating?
Patient: I'm not feel like eat so much most of the time
Doctor C: Is it?
Patient: Yeah
Doctor C: But you are lucky enough not to ( ) hey? ((chuckle))
Patient: ((laughs)) I'm not fat people. It's my body, yeah it's my body
Doctor C: It's your normal body, that's your normal body. Your body has not changed
Patient: No
Doctor C: It's not like it's bigger or anything
Patient: Mh-mh
Doctor C: °°° (Let me see) °°°They did took your blood hey?
Patient: Uhmm
Doctor C: I just need to look for that result. Sometimes they put it at the back
Patient: At the back oh
Doctor C: But it was definitely taken hey
Patient: Yeah
Doctor C: Any other problems? How is life treating you? No other problem?
Patient: The itching, the problem is
Doctor C: Your body is itching?
Patient: Not my body, actually here at the leg
Doctor C: Is the leg, is there something there that causes the itching, any problems with the skin or not?
Patient: Nothing
Doctor C: Show me
Patient: Here like this thing
Doctor C: Uhum ok and coughing anything like pus that's running?
Patient: No, nothing
Doctor C: Nothing, nothing
Patient: Nothing
Doctor C: Is it? Oh remember the days that they were sticking needles in you and all those kind of stuff?
Patient: Uhmm I remember
Doctor C: All gone now
Patient: All gone ((laughs))
Doctor C: So are you happy with the ARVs
Patient: I am happy because the first time I started ARVs, it's gone.
Doctor C: Is it
Patient: I see it's working
Doctor C: So what's happening in the community, do people respect people on treatment or do you think there is still stigma?
Patient: Uhumm
Doctor C: Is there stigma still?
Patient: Uhmm

55	**Doctor C:**	((yawns, laughs)) Going through the whole file and then I go into things like that. Ok so that was done on the 5th of March [2009]
56	**Patient:**	[and 9]
57	**Doctor C:**	So your CD4 count is 467 ok?
58	**Patient:**	It's down now
59	**Doctor C:**	Yeah but it's not too much. It goes up and down and things like that. So that's what
60	**Patient:**	It happens like going down
61	**Doctor C:**	Your CD4 goes a bit up and down. In normal people without HIV it also happens like that
62	**Patient:**	Ok
63	**Doctor C:**	Errh the liver is fine ((I just have to put that here)); liver is working fine. I want to discuss this with you. This is your viral load; this is the one that tells you if there are viruses in the blood. I want to tell it when we take blood from you we take the blood to errh a lab-lab, to a lab. At the lab they take photos of the blood
64	**Patient:**	Uhumm
65	**Doctor C:**	And you look at the photo, then we see in this drop of blood the number of CD4
66	**Patient:**	Ok
67	**Doctor C:**	And then we also look in it to see if there are any viruses in it and if we see viruses in it then we report it. Now previously what we reported we didn't report any viruses in your blood
68	**Patient:**	Ok
69	**Doctor C:**	but this time we did see 27 viruses, not a lot only a [few].
70	**Patient:**	[few] Ok
71	**Doctor C:**	Yes but we need to be careful. You do take your medicine everyday hey, you never miss it
72	**Patient:**	No I took it
73	**Doctor C:**	Is it?
74	**Patient:**	Yes
75	**Doctor C:**	That's great, so it was good. But just remember that that errhm we do see some viruses in your blood.
76	**Patient:**	Uhmm
77	**Doctor C:**	Now that is something we need to understand that the ARV treatment, the treatment only kills the viruses in your blood
78	**Patient:**	Uhmm
79	**Doctor C:**	It don't kill the viruses in the rest of your body
80	**Patient:**	Ok
81	**Doctor C:**	It stays in the vagina.
82	**Patient:**	Ok
83	**Doctor C:**	It stays in the glands. It stays everywhere in your body and things like that. So every day there is new viruses in your blood, so that is why we have to carry on treating people
84	**Patient:**	Uhumm
85	**Doctor C:**	But we are very excited, we've been to the congress and it looks like with things like this people can live for many years on the treatment which is, I am very happy about that
86	**Patient:**	Hmm ok
87	**Doctor C:**	You're not planning any pregnancies or anything like that?
88	**Patient:**	No
89	**Doctor C:**	Nothing? ((laughs)) Is it? How many children do you have?

90	**Patient:**	It's only one doctor
91	**Doctor C:**	Only one but you are not going to get pregnant again because you must be very careful for when there is viruses in your blood, then it can go to the baby
92	**Patient:**	Hmm ok. But if I have to plan to make a baby I will report for the doctor first if
93	**Doctor C:**	Great, that will be wonderful if you do that. I just want to see, you started in February 2007. That's two years on treatment; two years and two months hey?
94	**Patient:**	Yes
95	**Doctor C:**	Ok, no TB, no coughing
96	**Patient:**	No
97	**Doctor C:**	Is it? Great so I'm going to make a happy face here hey? P is happy, I'm happy
98	**Patient:**	((Laughs)) Ok it's fine. The problem is I'm working at Pick n Pay. I'm sitting in chair and I think my body is tired because I am stand too much
99	**Doctor C:**	((laughs)) So you are working hard
100	**Patient:**	Yes working too hard
101	**Doctor C:**	Listen errh Pick n Pay, you are working in Pick n Pay?
102	**Patient:**	Yes
103	**Doctor C:**	Are you full-time employed?
104	**Patient:**	No I am casual
105	**Doctor C:**	Is it? Because
106	**Patient:**	But I am casual-permanent because we don't have contract outside now we finish we go home. We are working many years and then we get a post to apply for a permanent post
107	**Doctor C:**	Because the people from Pick n Pay errhm I know the manager Ackermans isn't it?
108	**Patient:**	Hm the big guy
109	**Doctor C:**	The big guy, his wife created a special fund
110	**Patient:**	Yes I know
111	**Doctor C:**	for people working at Pick n Pay that you can apply for and then they give bursaries to your children
112	**Patient:**	Hmm
113	**Doctor C:**	Have you applied for it
114	**Patient:**	Yes
115	**Doctor C:**	Oh I see you are one of them. Ok I think that must be because they came to me and I said I think the important thing is that we actually to make sure that you know so that they help your child can study
116	**Patient:**	Yes
117	**Doctor C:**	Oh ok you are happy?
118	**Patient:**	Yes and we have the errh something like a support office in Claremont, the room that the people who is HIV then you go there and explain your problems all of those things
119	**Doctor C:**	Ok so you follow. That's why you are such a nice patient hey? Great and things. So everything is fine in ((name of location))?
120	**Patient:**	Yes((chuckle))
121	**Doctor C:**	So you are happy?
122	**Patient:**	I am happy because I'm talking with my status to my friends; guys don't stay and if you feel you see some other things and you are coughing you must go to the clinic
123	**Doctor C:**	Eh man I'm going to put a star next to your name hey? Ok we've painted

our system a bit better I hope. We are going to give you, you will see the dates until December 2000 and

124 **Patient:** 9

125 **Doctor C:** No, 2010

126 **Patient:** 10?

127 **Doctor C:** So we will be working out our dates, you will be a 'yellow' patient. So I want to put you on a two-monthly system so that we can give you your medicine for two months. So you have been here on the 9th, are you happy to come here on a Thursday?

128 **Patient:** Thursday? Yes I don't have a problem

129 **Doctor C:** So the fourth of, so, I'm going to see if they can give you medicines for two months today ( ) for two months. So you are going to get ( ). And then the 4th, you need to get medicines on the 4th of June. You don't need to wait for me

130 **Patient:** Uhumm

131 **Doctor C:** And then you get a ( ) for July. And then we need to see you in July at the end of July, the 30th of July

132 **Patient:** Ok it's fine

133 **Doctor C:** Now the first thing that's important we need to decide, you started in February, February, March, April, June, agh, February, March, April, May, [June, July, August].

134 **Patient:** [June, July, August]

135 **Doctor C:** So in August we want you to have bloods again

136 **Patient:** Ok

137 **Doctor C:** And then I just need to see you two months after that

138 **Patient:** Ok

139 **Doctor C:** ((So we'll see what we can do)). That is your next doctor's visit. If you have any problem please try to report it early

140 **Patient:** Ok

141 **Doctor C:** (0.34) ((ruffle of paper)) So your first language is Xhosa?

142 **Patient:** Yes

143 **Doctor C:** Do you speak Afrikaans too?

144 **Patient:** Yes, I speak Afrikaans

145 **Doctor C:** Where did you pick up all the languages?

146 **Patient:** ((chuckles))

147 **Doctor C:** Why are you so good at… are you finished Matric? What Standard did you finish?

148 **Patient:** I'm finished at Standard 9, Grade 11 because I was pregnant that time so I look work after and I didn't go further to finish school.

149 **Doctor C:** Are you going to finish school

150 **Patient:** I want to go

151 **Doctor C:** I think because that is the way you can become manager of Pick n Pay hey? ((laughs))

152 **Patient:** I don't want to be manager of Pick n Pay because Pick n Pay staff is stressed

153 **Doctor C:** Is it? Is very stressed.

154 **Patient:** Oh Yes

155 **Doctor C:** But errhm you know I try to tell people that listen, HIV is not going to kill you. You're going to live very long still so you must make the best of the time that is left. Sometimes when people have Matric it just opens doors for you hey?

156 **Patient:** Hmm

157	**Doctor C:**	Because can you get promoted or not, do they want you to have a higher grade or not if you want to go to be, you must have Matric or not or it's not difficult to work at Pick n Pay. Are they difficult about, do you need Matric to be a cashier or not?
158	**Patient:**	No
159	**Doctor C:**	Oh ok
160	**Patient:**	Although you understand you see when I'm starting at Pick n Pay, I write two tests for the cashier and I passed both of them of those two tests.
161	**Doctor C:**	So actually you would have been higher up if you had passed Matric
162	**Patient:**	Yes
163	**Doctor C:**	So that was sad
164	**Patient:**	It's sad yes because my mother didn't have money to give me to further take the study. But I want to finish my Matric even there at Boland College
165	**Doctor C:**	Promise? You know what happened; I have patients that finished the Comrades
166	**Patient:**	Oh
167	**Doctor C:**	Yeah I've done that and there was other patients that have finished Matric, that's possible hey? There is the other patients that have finished their degrees and things.
168	**Patient:**	Ok
169	**Doctor C:**	So we just need to dream
170	**Patient:**	Yes
171	**Doctor C:**	So this 4th will be medicine, the 30th of 7 /09 will be meds and blood (0,47)
172	**Patient:**	But I also think I want to apply for this counselling, for the counselling of people at the clinic.
173	**Doctor C:**	You will be very good, I can see that you will be a good counsellor
174	**Patient:**	But I don't know where to go
175	**Doctor C:**	But you are not going to get the same pay; Pick n Pay, pay much better. So be careful
176	**Patient:**	((laughs)) I understand
177	**Doctor C:**	You understand they don't pay that much
178	**Patient:**	Hmm
179	**Doctor C:**	So there is the form, this is the next day and we think that would be the next
180	**Patient:**	Ok thank you
181	**Doctor C:**	Thanks for the recording ok.
182	**Patient:**	Ok doctor
183	**Doctor C:**	Make sure that they give you two-months' treatment.
184	**Patient:**	Ok doctor
185	**Doctor C:**	Nice, you need to work this Easter?
186	**Patient:**	Oh yes I am going work now
187	**Doctor C:**	Oh ok I am going on leave now
188	**Patient:**	((You are not going to put my thing in the computer?))
189	**Doctor C:**	We need to get used to the computer hey? ((laughs))

Appendix 17: Consultation 17

1	**Doctor C:**	This is just to check me out in my English. What is your first language?
2	**Patient:**	Xhosa
3	**Doctor C:**	Xhosa
4	**Patient:**	Yes
5	**Doctor C:**	And do you speak Afrikaans ah English?
6	**Patient:**	Only English not Afrikaans
7	**Doctor C:**	Not Afrikaans bietjie? ((chuckle))
8	**Patient:**	No
9	**Doctor C:**	So my first language is Afrikaans.
10	**Patient:**	Ok
11	**Doctor C:**	Now one of the things that I think is important is that we use translators but sometimes I will like to talk to the patients too.
12	**Patient:**	Ok
13	**Doctor C:**	So now we need to learn, I need to learn to use in English so they are going to help me with that.
14	**Patient:**	Ok
15	**Doctor C:**	So how are you doing, how are you feeling?
16	**Patient:**	I am feeling alright now
17	**Doctor C:**	Is it?
18	**Patient:**	It's better to change that ((I mean the last one))
19	**Doctor C:**	Is it? So they started you with a new one
20	**Patient:**	Yes last month
21	**Doctor C:**	And how do you feel? Is that not too strong for you?
22	**Patient:**	No it's right
23	**Doctor C:**	Is it? They were worried about your body changing. What was the problem with your body?
24	**Patient:**	The weight, I'm losing the weight when I was using that one
25	**Doctor C:**	Is it, is it?
26	**Patient:**	Yes
27	**Doctor C:**	Ok, ok you were losing weight and they were worried about the acids were coming into your body and things like that. Now you are taking only the tablets. So I just want to see what they have done with the new one. So you are taking the one in the ...night
28	**Patient:**	Yes only in the night
29	**Doctor C:**	You now take all three just at night time
30	**Patient:**	Yes
31	**Doctor C:**	Is that easy or it's difficult?
32	**Patient:**	It's very easy that one
33	**Doctor C:**	It's very easy. Is it, is it? ((chuckle)). Ok and then they was worried about that you may be have high sugar but that was never a problem before, was it?
34	**Patient:**	Yes (that time I used that one)
35	**Doctor C:**	((Never had sugar)).Ok let's just write it here that you are one month on new regime. So that means that we have put you now on 3TC, D4T agh, 3TC, ( ), and Efavirens. Now what was very important why they bringing you back to me today is we need to make sure that your kidneys is working well ok?
36	**Patient:**	Ok
37	**Doctor C:**	because those new treatment, the one that we use with the ( ) the new tablet, the new one Virate, that tablet goes through your kidneys
38	**Patient:**	Ok

39	**Doctor C:**	Now your kidney is very important. Why do you think is...the kidney is important? Anything yes?
40	**Patient:**	because they, my kidneys supply water to my body
41	**Doctor C:**	Very good, very good. What happens, all your blood
42	**Patient:**	Yes
43	**Doctor C:**	All the blood that pumps goes through the kidney
44	**Patient:**	Yes
45	**Doctor C:**	So your kidneys is like cleaning your blood. So all the things that need to go out of your blood the kidneys do that
46	**Patient:**	Ok
47	**Doctor C:**	So it's like the heart pumps and then it pumps all the the blood goes through the kidney and then the kidney takes all the things that they don't want in the body and they get out of the body and they put the things that need to stay in the body, they [keep it in].
48	**Patient:**	[keep it in] yes
49	**Doctor C:**	So if you have problems with your kidney and if you are going through what we call kidney failure, your body is not able to keep remove all the bad stuff out of the body. So we also need to take some of your blood and in the blood we can see if there is some of the bad stuff that's not removed, that stays behind
50	**Patient:**	Ok
51	**Doctor C:**	So now, but now the problem with ( ), the new medication is that in some people it can damage the kidneys
52	**Patient:**	Ok
53	**Doctor C:**	So that is why we are checking against things like that but it looks very well. On the 12, I just want to see ( ) (0.45)((flipping pages)) they didn't take, so you started the treatment on the 12, ney?
54	**Patient:**	Yes
55	**Doctor C:**	So it's a month later. They didn't take, in two weeks' time they didn't take any blood from you
56	**Patient:**	No
57	**Doctor C:**	((they never did it))
58	**Patient:**	((They took the blood last two months))
59	**Doctor C:**	I just want to work out
60	**Patient:**	((But my CD4 count is very high))
61	**Doctor C:**	Very good, yes that's great so that we know the medicine that's worked very well. But it's just that, it's just that errhm, errhm, the only problem is that they got too strong for your body
62	**Patient:**	Ok
63	**Doctor C:**	How old are you?
64	**Patient:**	36
65	**Doctor C:**	36 (0.328) ((speaks to Nursing sister in Afrikaans))
66	**Nursing Sister:**	((Responds in Afrikaans))
67	**Doctor:**	(0.53) I'm just working out how good your kidney is working ok?
68	**Patient:**	Hmm
69	**Doctor C:**	(0.23) Ok your kidneys are working well but we need to check it today again ok? The Sister is going to be forced to take blood from you hey?
70	**Patient:**	Ok
71	**Doctor C:**	What are you going to do Easter; any, you're going anywhere, Easter this

		week-end are you going
72	**Patient:**	Yes I am going to Easter
73	**Doctor C:**	Where are you going?
74	**Patient:**	Eastern Cape
75	**Doctor C:**	Eastern Cape! When are you coming back?
76	**Patient:**	May be on June
77	**Doctor C:**	JUNE? NO YOU [CAN'T COME]
78	**Patient:**	[On May]
79	**Doctor C:**	May, you must come in a month's time hey?
80	**Patient:**	Ok
81	**Doctor C:**	Are you leaving today?
82	**Patient:**	Today (0.5). So doctor I can give me treatment if
83	**Doctor C:**	I can't give you. It's a new treatment, you must come back
84	**Patient:**	Ok
85	**Doctor C:**	Early in May I will give you a month's treatment but not ((now)) because we need to check your kidneys to make sure they are ok, ok? (0.15) Because if this, when the treatment is stable and you are ok then we can give you two months. We will do that. But it's jus now that it's a bit of a problem huh?
86	**Patient:**	Ok
87	**Doctor C:**	(0.50) Errhm you're still at ((name of rsidencial address)) neh?
88	**Patient:**	Yes doctor
89	**Doctor C:**	( ) (0.10) ((flipping of pages)) This is just for new dates so we just going to check. So you are seeing us on the 7 of May. You MUST come back then, hey?
90	**Patient:**	Yes
91	**Doctor C:**	((Meds and doctor. So you need to see the doctor)). So where in the Eastern Cape are you going to? Where is your home in the Eastern Cape?
92	**Patient:**	((For my mother))
93	**Doctor C:**	In which town, which place in the East...?
94	**Patient:**	((name of town))
95	**Doctor C:**	((Name of town))
96	**Patient:**	Yes
97	**Doctor C:**	Oh ok, ((scribbling)) (0.40) Great, I just need to put you on the computer. Ok. Anything more, any more questions?
98	**Patient:**	No

Appendix 18: Consultation 18

1	**Doctor C:**	Hi L, do you speak English?
2	**Patient:**	Yes
3	**Doctor C:**	((chuckles)) But your first language is Xhosa
4	**Patient:**	It's Afrikaans
5	**Doctor C:**	It's Afrikaans. Ok so you speak Afrikaans and English
6	**Patient:**	And Xhosa
7	**Doctor C:**	And Xhosa. So you, what do you speak at home?
8	**Patient:**	I speak Afrikaans at home
9	**Doctor C:**	And where did you teach, where did you learn Xhosa?
10	**Patient:**	I learnt it from my parents
11	**Doctor C:**	So your parents is Xhosa and your husband?
12	**Patient:**	He is a Xhosa also.
13	**Doctor C:**	He's also Xhosa. But, errhm so you grew up with Xhosa at home?

Patient: No. I grew up like (coloured with my grand mom)
Doctor C: Ooh
Patient: But then in the middle of the year I went to stay with my parents
Doctor C: At what age?
Patient: I was 12
Doctor C: 12
Patient: ( )
Doctor C: Is it? So you speak English, Xhosa and [Afrikaans]
Patient: [Afrikaans]
Doctor C: Yho you are great hey because I've been working in this work now for three-four- five years and I'm just too lazy. No, not the word lazy but I am not just picking up Xhosa, you know? I guess I'm just late for that and thigs like that. Ok we can ignore that. Let's just go on with what's happening to you. So you were a bit in trouble after you left us and then you started with treatment again, when was that? You started in March? Errhm that was on the 11 of March. So that is one month on treatment AGAIN. How are you feeling this time? Are you motivated? Are you going to stay on your treatment?
Patient: Yes
Doctor C: What is different this time?
Patient: It's a little bit lighter for me now
Doctor C: Is it, why?
Patient: Because that time things were too much for me with the death of my husband and the children and my mother who is on that side, I must look after her also. Now I am staying by myself at home. I have my own place
Doctor C: At the moment?
Patient: Yeah ( ) now it's fine. My sister is staying with me now and she is helping me something so
Doctor C: Is it? I'm going to try to talk to you in this way ok. Just to say, listen, on a scale of one to ten how confident are you that you are going to stay on treatment this time
Patient: Because I was seeing ((body)) like in leaving me fast
Doctor C: Yeah?
Patient: And it was like in I must be serious about this because I must think about my babies because they need me most. I was thinking a lot of things and especially that their father is not there anymore. I have to take this serious ((because it's each day I can live is definitely good for them))( )
Doctor C: Hmm that's a big; you have a lot of motivation this time, more than in the past
Patient: More than in the past
Doctor C: Is it?
Patient: I am very serious about this now
Doctor C: Do you see the medication is too difficult to take
Patient: No it's not too difficult
Doctor C: It's that you just don't want the up-side-down side of life. You want a life that's
Patient: Yes, a good one
Doctor C: But it's difficult hey because I've seen rich people, people with a lot of resources who also have up-side-down lives and then you see poor people that have little but they can organise their lives. So it's also about how you think about organising your life and things like that
Patient: Hmm

45 **Doctor C:** Our clinic and how we run our clinic, is it a burden for you or is it something that's a burden to take medication or does it helps you to take medication? [What]
46 **Patient:** It's [something that I'm learning something out of it
47 **Doctor C:** Is it?
48 **Patient:** like I am HIV positive and then these friends of my they would come and talk the sex things and so on and then I can't even explain to them
49 **Doctor C:** Hmm so is the clinic a reason for not going on treatment or it is a reason for staying on treatment? Because it can be difficult when you come to clinic you need to waste a day, you must stay in the row. That can be a reason, you can say I'm angry every time I'm here I'm between these patients and I don't like it. Do you get the feeling?
50 **Patient:** No I don't have a problem. No, to me it's like people can sit here and I'm not affected by them. It's like you are not better than me and I am not better than you and I'm still the same person, so I can't judge someone else by looking at them or of feeling bad or anything like that, no
51 **Doctor C:** Hmm ok I'm very proud of you because you are 100% now hey after this first month on having treatment now again. You haven't missed any of them?
52 **Patient:** No
53 **Doctor C:** You're sure? So I am going to be like a political guy because it is looking like politics is coming the rest of the month. I think it's like one of the problem in South Africa is that we don't believe in each other
54 **Patient:** Hmm
55 **Doctor C:** And we don't have those things that we say for people I believe in you because everybody tries to say this one is this and this one is that. I have just one gift for you and this is in four words 'I believe in you'. I believe that you are going to make a success this time. Is it a deal?
56 **Patient:** It's a deal
57 **Doctor C:** IS IT A DEAL? And I don't think you're, I think you are a wonderful person; you can speak three languages, ( ) you can look after your kids but we all go through difficult times and things. And I'm not going to ((fight with anything else with treatment)) We don't need any new bloods, so you need to have a wonderful Easter and then I will see you in May, ok? Anything you need to ask me?
58 Patient: No, just the problem here, up
59 Doctor C: What's the wrong there? (0.10) Errh, I just want to get the light to look at it (0.13) ((opening and closing of door)) Oh ok, the white stuff there?
60 Patient: Mh-hm, yeah
61 Doctor C: Ok I'll give you something for that. Did you use some of those ((microstatum drops)) before?
62 Patient: Yeah, I did
63 Doctor C: Do you still have
64 Patient: No, I don't have
65 Doctor C: Ok, I'll give you some
66 Patient: Ok
67 Doctor C: (0.13) And you are not going to get pregnant, hey?
68 Patient: No, I'm not involved now
69 Doctor C: Do you use prevention?
70 Patient: No, I'm not on that. But I am not involved with anyone now….
71 Doctor C: No TB symptoms?
72 Patient: ((...skin, it's like))

73	**Doctor:**	Itching? You know, as we get the virus more under control, it do get better
74	**Patient:**	Yeah
75	**Doctor C:**	(0.18) We are going to... did you put in your...what we are going to do now is, we are going to put our patients into...we're reorganising. We are going to put them on the computer so that we can just check better. So you are going to be a 'yellow' patient ((speaks in Afrikaans and chuckles)), I'm just joking. So you are going to stay on this, you are going to have dates, you will see till 2011
76	**Patient:**	Ok
77	**Doctor C:**	But I... when we will do it, so you will see, you will be every time like the erh, like the different times, errhm that's your dates for the errhm the rest of the year. So you will know plus or minus when you need to come back and things like that
78	**Patient:**	Ok
79	**Doctor C:**	But we will still give you these dates. But if that's going to help you to stay on treatment, you can see the dates that we expect you to come back
80	**Patient:**	Ok
81	**Doctor C:**	Now if you stay with them good, we can give you two- months' treatment ((we try to do)) but we first just give you for one month ( )
82	**Patient:**	Ok
83	**Doctor C:**	Did I put in your ( ), now let's give you a clean one. You can use that to just plan your future. So if you go away or something, you know that's my dates that I probably need to come and then we can change this according to that. (0.15) Last time did they've given you some of those pink tablets, hey? Did that help? ( )
84	**Patient:**	Yes, it helped, yeah, it was very good
85	**Doctor C:**	Then it start again? Ok, so I will first just give you the drops ok? (0.22) ( ) Ok, thanks, good luck hey? What's the secret words?...((chuckles)), 'I believe in you'
86	**Patient:**	I believe in you
87	**Doctor C:**	((Chuckles)) Ok, thanks

Appendix 19: Consultation 19

1	**Doctor D:**	Alright, ok Z, how are you?
2	**Patient:**	I am fine and you
3	**Doctor D:**	I'm alright thank you. As I see today is your visit for the doctor so I'm quickly going to look through your file to update myself then I'm going to speak to you alright?
4	**Patient:**	Ok
5	**Doctor D:**	((Ok, let's just have a look here)), tell me when did you start the ARVs, can you remember?
6	**Patient:**	Yeah, 2006, 20 October
7	**Doctor D:**	Oh shoh you are quite good with that hey? So many patients don't even know when they started the ARVs
8	**Patient:**	((Ah))
9	**Doctor D:**	So I can see you are going to be two years six months. So it's actually time again to take your CD4 count and your viral load. They take it every six months neh?
10	**Patient:**	Yes
11	**Doctor D:**	Let me just see your tablets. It looks almost like you took too many tablets, hey?

12 **Patient:** No
13 **Doctor D:** You have three different ARVs hey, do you know their names?
14 **Patient:** ((negation sound)) It changed this *vanag*, it it changed *mos*
15 **Doctor D:** Ok so it's going to change today
16 **Patient:** Yeah
17 **Doctor D:** Ok, let me just see here...so last time what was the problem? They said that the errh, we call it the lactate. It's like errh it's sort of to describe it, it's like errh a sourness is in your blood. It's the easiest way for me to describe it. When you do exercise and you are stiff the next day that is also a sourness in the blood. So sometimes the ARVs causes that sourness in the blood and then you lose the weight like you did last time. You remember they did that pin prick hey, for the blood
18 **Patient:** Yeah
19 **Doctor D:** And they said that that was a bit high and that is why we also decided to order that new tablets because of that, so we can start you on a new regime today. Do you understand?
20 **Patient:** Yes. I'm coughing every day the whole, the whole month I'm coughing ((and Ive been sore))
21 **Doctor D:** Is is it a dry cough or is there something coming out?
22 **Patient:** Something coming out, white
23 **Doctor D:** White and is there blood inside?
24 **Patient:** ((negation sound))
25 **Doctor D:** And are you sweating at night?
26 **Patient:** No
27 **Doctor D:** Now tell me the appetite, how is your appetite?
28 **Patient:** No appetite
29 **Doctor D:** No appetite, ok. So it can be an infection that you have in the lungs or it can also be may be the TB that you have neh, so now we will have to check that.
30 **Patient:** Ok
31 **Doctor D:** Do you have any other problems?
32 **Patient:** No, no other problem
33 **Doctor D:** Did you have TB before?
34 **Patient:** Yeah
35 **Doctor D:** Do you feel the same now?
36 **Patient:** May be, may be ((chuckle)) I'm coughing too much
37 **Doctor B:** ((laughs)) Ok errhm so I'm just quickly going to write here your complaints and then I'm going to examine you, alright?
38 **Patient:** Ok, hmm
39 **Doctor D:** **(**0.40)
40 **Patient:** ((opening and closing of door)) I say doctor, I want paper for the work
41 **Doctor D:** Ok I'll give you the paper for work neh?
42 **Patient:** Hmm
43 **Doctor D:** I'm just quickly going to listen to your lungs ( ) so you can just sit like that, first you open up your mouth for me so I can look inside there. Ok, you can close it and you just sit like this and now you must breathe in and out through your open mouth neh? Ok you can breathe ((breathing)) (0.28) Alright that's fine. Now I've listened to your lungs now and I don't hear anything that's suspicious, so it can only be may be the flu or the infection that you have , not the TB
44 **Patient:** Ok
45 **Doctor D:** But we must always be suspicious of the TB, so I'm going to give you

		some antibiotics for the infection. It will get better if it's only the infection
46	**Patient**	Ok
47	**Doctor D:**	But I'm also going to ask you to to cough again in that small bottle, that sputum; that slime to send away for the TB test alright?
48	**Patient:**	((Speaks in Afrikaans))
49	**Doctor D:**	((responds in Afrikaans)) Did you give it in? How many bottles did you give him?
50	**Patient:**	Two
51	**Doctor D:**	Two bottles oh, did they give you some antibiotics
52	**Patient:**	Yeah
53	**Doctor D:**	Did they give you some tablets, some antibiotics to take?
54	**Patient:**	((To drink?))
55	**Doctor D:**	Yeah and do you have it here?
56	**Patient:**	((yeah but see I'm feeling better)) and then if you finish the pillis it start again
57	**Doctor D:**	Do you know the name of the tablets?
58	**Patient:**	No
59	**Doctor D:**	Did you bring it in the packages today
60	**Patient:**	No ((the pai:: n)) the purple and blue one, the purple and [( )]
61	**Doctor D:**	[Oh oh it must be the amoxo] I think. So when did you go on that treatment?
62	**Patient:**	Treatment?
63	**Doctor D:**	Yeah that antibiotic, that purple and the blue side, when did they give you that?
64	**Patient:**	Erhm may be on Monday
65	**Doctor D:**	On Monday
66	**Patient:**	Yeah
67	**Doctor D:**	Are you still taking them?
68	**Patient:**	Yeah
69	**Doctor D:**	Ok so you've not finished with the tablets now?
70	**Patient:**	No, I've finished with the ( ) the other one is still here
71	**Doctor D:**	Oh so the other one the blue and purple one, you are still taking them?
72	**Patient:**	Yes
73	**Doctor D:**	Are they at home?
74	**Patient:**	Yeah they are at home
75	**Doctor D:**	Ok, you must finish those ones also [ok?]
76	**Patient:**	[Ok]
77	**Doctor D:**	Because that sounds like the antibiotic and it's not going to help if you stop ((half-way)) ok?
78	**Patient:**	Ok
79	**Doctor D:**	So I'm going to give you some pain tablets also and then we'll follow you up for the results of the TB tests, alright?
80	**Patient:**	Ok
81	**Doctor D:**	I'm not going to do X-ray today because your lungs sounds alright. I don't think it's necessary but when we have the results next time when you come then we'll decide again about the X-ray, ok?
82	**Patient:**	Ok
83	**Doctor D:**	Now, I think I'm first going to, let me just see, you have about a week of tablets left the old ones. So you must hand that in and then we're going to give you the new ones and N will explain to you how the new tablets looks like and how you must take them, alright?
84	**Patient:**	Ok ((cough))

Appendix A: ETHICAL CLEARANCE

Researcher:	Ms Diana Njweipi-Kongor
Research Project:	Discursive features of medical discourse in a Western Cape HIV/AIDS clinic where English is the lingua franca
Nature of the Research Project:	D Phil study in the Department of English, SU
Supervisor:	Dr. N Bangeni, Department of English, SU
Co-supervisor	Prof. C. Anthonissen, Department of General Linguistics, SU
Reference number:	94/2008
Date:	21 July 2008

This research proposal was considered by the Ethics Committee in an internet consultation in July 2008 in terms of the Guidelines on the Ethical aspects of Scientific Research as stipulated by Council on 18 September 1996; the purpose being to ascertain whether there are any ethical risks associated with the proposed research project of which the researcher has to be aware or, alternatively, whether the ethical risks are of such a nature that the research cannot continue.

DISCUSSION

The Ethics Committee received the following documentation:

- A fully completed application form – but it was not signed by the Chairperson of the Department of English
- An extended research proposal
- One informed consent form

In this study, recordings will be made of 20 to 30 interviews conducted in English between doctors and patients at the Stellenbosch Day Hospital where both doctors and patients do not have English as their first language. These recordings will be transcribed and analysed.

No clinical records of patients will be used in this study.

It is mentioned in both the application form and the research proposal that the research will also entail follow up interviews. No interview schedule was attached to this application.

It was also mentioned that permission for this research was obtained from Dr. Nelis Grobbelaar, Superintendent of the clinic mentioned above. The letter to this effect was not included in this application. The researchers should also note that permission for this research must also be obtained from the Department of Health of the Western Cape.

However, he Ethics Committee is satisfied that there are no major ethical risks involved in this study, and that the researcher and her supervisors are well aware of the requirements stated in paragraph 2[3] of the Guidelines on the Ethical aspects of Scientific Research regarding informed consent, voluntary participation, and confidentiality of personal

information – in so far as this is applicable to this study.
However, there are a few important points that need to be addressed by the researcher to prevent exposure to criticism from an ethical point of view:

1. Informed consent should be obtained in a manner that protects patients' right to privacy. Patients visiting doctors have the right not to have the fact that they are HIV positive disclosed to third parties. This would imply that the doctor or some other person would have to initially solicit patients for participation in the study. The clinic cannot decide on behalf of the patient to reveal to the researcher who is HIV positive and can be approached for participation in the study. The researcher thus will have to approach the medical staff at the clinic to assist in this process of initial soliciting, and to ask the medical staff to only refer patients to the researcher who are willing to reveal their HIV status (in confidentiality) to the researcher. This may have implications for the informed consent form, and if necessary, the informed consent form should be changed accordingly (also see 2 below).

2. The informed consent form creates the impression that informed consent should only be obtained from patients in the interview. The fact of the matter is that the doctors are also subjects of the research, and are also entitled to informed decision-making, voluntary participation and confidentiality. Informed consent should thus also be obtained from the doctors participating in the research. This may have implications for the choice of formulations in the informed consent form. If both parties participating in these interviews cannot be accommodated in a single informed consent form, then two separate forms should be drawn up for each target group. Any changed informed consent form should be submitted for filing at the office of Ms Maryke Hunter-Hüsselmann of the Division for Research Development of SU.

3. Given the fact that participants in this research are not first language English speakers, but typically either Afrikaans or Xhosa, the researchers should seriously consider to have the informed consent form translated into the first language of the participants.

4. In paragraph 2 of the informed consent form, the "the possibility of a follow-up" is mentioned. This is very vague and should be specified in more detail.

5. Paragraph 4 of the informed consent creates the impression that participants in this research will benefit directly from this research – which is clearly impossible, since the researcher cannot intervene in the interview. This should be clearly specified in this paragraph – to prevent any false expectations that participants may form when reading this section. Conversely, patients should be reassured that their participation in this study does not constitute an "experimental situation" in which the quality of medical service will be of a lower standard than it would have been otherwise.

6. Further to paragraph 4 above, paragraph 2 should be expanded to explain exactly how the recordings will be made, and that the researcher will leave the room after the recording equipment has been activated.

7. Further to paragraphs 4 and 5 above, it should be made explicit in paragraph 3 of the informed consent form that the doctor will switch off the recording if discomfort is experienced. It speaks for itself, as stated in the application form, that the researcher should not be present during the interview between doctor and patient, and that any intrusion of the researcher to attend to equipment during the interview should be avoided at all times.

8. The respective departments and the affiliation to Stellenbosch University of the two supervisors should be repeated in paragraph 8 of the informed consent form.

9. In paragraph 9 of the informed consent form, the word "Unit" should be replaced with "Division".

10. Paragraph 7.2 of the Application Form requires an indication of how and where the data of this research will be kept in safety, so as to prevent unauthorised access of third parties not participating in the research. This should be specified in a note to Ms Maryke Hunter-Hüsselmann of the Division for Research Development of SU.

11. Given that explicit mention is made in the application of qualitative interviews, the researcher should submit an interview schedule to Ms Maryke Hunter-Hüsselmann of the Division for Research Development of SU. If this interview schedule is still under construction, it should be indicated in a note to Ms Maryke Hunter-Husselmann – and the schedule should be submitted to her as soon as it is ready.

RECOMMENDATION

On the basis of the information made available to it, the Ethics Committee cannot foresee any reasons why the proposed research may not continue, provided:

a. That the researcher will remain within the procedures and protocols indicated in the proposal.
b. That the researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
c. That the research may have to be submitted again for ethical clearance if there is substantial departure from the existing proposal.
d. That the applicant gives attention to the matters raised in the paragraphs above to minimise ethical risks and submit the outstanding documentation to Ms Maryke Hunter-Hüsselmann.

On behalf of the Ethics Committee 21 July 2008

Johan Hattingh, Mustaqeem de Gama, Callie Theron, Ian van der Waag, Elmarie Terblanche, and Clint Le Bruyns

---

Appendix B: CONSENT TO PARTICIPATE IN RESEARCH

Title: Discursive features of medical discourses in a Western Cape HIV/AIDS clinic where English is the lingua franca.

You are asked to participate in a research study conducted by Diana Njweipi-Kongor, Dr. N. Bangeni and Dr. C. Anthonissen from the Department of English and General Linguistics respectively, at Stellenbosch University. The results of the research will contribute (i) towards a PhD thesis by Diana Njweipi-Kongor (ii) towards a research project that is supported by the National Research Foundation. You were selected as a possible participant in this study because you are undergoing medical treatment on a programme where I am interested in investigating how doctors and patients who have different first languages communicate in English as lingua franca.

1. PURPOSE OF THE STUDY

To investigate South African discourses related to the transfer of information on HIV/AIDS in a cross-cultural setting where participants have different first languages (in this case Xhosa and Afrikaans) and have to communicate in a second language (English) in which they both have proficiency in varying degrees. The success of such intercultural communication is very important because the recovery of a patient depends to a reasonable extent on effective transfer of information between the participants (doctors and patients).

2. PROCEDURES

If you are approached by one of the hospital staff soliciting your permission to take part in this study and you do volunteer to participate in it, you would be asked to do the following things:

You will be required to take part in a consultation with a doctor who is also a participant in the study and the conversation will be tape recorded by the doctor. The researcher(s) will not interfere with the consultation but would like you to go ahead with it as you would even if the recording was not being done. Our interest is merely in the language used by participants. The researchers will therefore at all times respect your privacy and confidentiality if you choose to disclose your identity and HIV status to them; and will not disclose your identity to anyone outside the project. The estimated time of your participation is the duration of the consultation at the Stellenbosch Day clinic.

3. POTENTIAL RISKS AND DISCOMFORTS

It is possible that during the course of the consultation you may feel uncomfortable with parts of the conversation that you would not like to put on record, and therefore, not to be taken up in the research project because they are too personal. At any such time, you may request that the doctor switches off the recording if discomfort is experienced. The researcher will respect any such requests made by you through the doctor and none of the material you do not allow would be used in the project even if it was already recorded.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There shall be no material or financial benefits due to participants (doctors and patients) in the study. Also, the quality of medical service provided to and received by participants

at the clinic will not be affected either negatively or positively because of their participation in the study. But considering that effective communication is crucial during consultation, it is only important for both doctors and patients to know how well they communicate with each other. This research will investigate communication between participants with different L1 at the Stellenbosch Day clinic, to determine what communication tools work well for them, and what may cause misunderstanding and how this might be resolved. The outcome may be better communication practices, so that both doctors and patients become more certain that they understand what the problem is and are able to negotiate more satisfying treatment options that are understood by all.

The research will also add to the knowledge on societies in transition such as South Africa and expand the scope of academic research in medical discourses and language research.

5. PAYMENT FOR PARTICIPATION

There is no financial or material payment for participation in the research.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of (i) allowing only the participating doctors and patients in the consultation room, with any of the three identified researchers only assisting to set the recorder in place for the recordings to be done and leaving the room after this is done(ii) by identifying participants (both doctors and patients) in the transcription of data and by using code names instead of their real names if these are mentioned at any stage in the data(iii) Removing from the thesis write-up any references that may specifically identify the participants.

Participants have the right to listen to the audio-tapes in which they are recorded immediately after the recording has been done or within a reasonable and practicable time if they so desire. The data will be preserved in audio tapes that will be safely kept following the rules and regulations of the department regarding such data, and the transcriptions thereof will be used for the write-up of the project. In oral presentation the recordings will be edited to minimally compromise the participants. These recordings will be used only for academic purposes and will be made accessible to the doctors concerned if need be.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so e.g. If it becomes evident that participation is detrimental rather than beneficial to any of the participants in the consultation.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

- *Principal investigator: Diana Njweipi-Kongor of the Department of English on 082 798 2368*

- *Supervisor: Dr. N. Bangeni also of the Department of English, Stellenbosch University on 021 808 2399*

- *Co-Supervisor: Prof. C. Anthonissen of the Department of General Linguistics, Stellenbosch University on 021 808 2006*

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maryke Hunter-Husselmann, Tel. 021 808 4623 at the Division for Research Development, Stellenbosch University.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to …….. by …….. in [*Afrikaans/English/Xhosa/other]* and *I am* in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study.] I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Subject/Participant or Legal Representative **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the representative]*. *[H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*Other*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____ _____

Signature of Investigator **Date**

Appendix C: Letter of application to conduct research

Njweipi-kongor Diana B.
Department of English
Stellenbosch University
Email: kongordin@yahoo.com
Cell: 082 798 2368
2008-11-05

Dr. R. Davids
Medical Superintendent
Stellenbosch Hospital
Western Cape Province

Dear Sir,

An application for permission to conduct research on the use of English as lingua franca at the Stellenbosch Day clinic in Adas Valley/environs.

I am a registered doctoral student at the Stellenbosch University. I am being supervised by Dr. Nwabisa Bangeni of the English Department and Prof. Christine Anthonissen of the Linguistics Department, both of the same institution. This study will be a partial fulfilment for the award of a PhD at the end of my course. It is one of three research projects that were approved for Prof. Anthonissen by the Medical Research Council and sponsored by the National Research Foundation (NRF) in 2006. Two of these projects have been suspended and only this one is going on as planned. It is presently self-sponsored and thankfully partially supported by the English Departmental Bursary Scheme.

I wish to apply for permission from your office for the above mentioned research. This permission is part of the requirements requested by the University's Ethics Committee from researchers working with human subjects such as the doctors and patients I intend to use in my study. Therefore, I am applying for permission to collect data at the clinic for a period of between at least six and at most eight weeks, commencing from the date the permission is granted. This time frame will allow me record between 30-40 consultations envisaged for the study. The research will focus on the use of English as a lingua franca during HIV consultations in a situation where both doctors and patients do not have the same mother tongue. The interest is to investigate what form the language takes in such situations and to particularly find out the linguistic features that are used to resolve misunderstanding when it does occur.

Although this research will not be of any immediate benefit to the participants, it is hoped that the findings will add knowledge to language issues in medical settings and contribute to the academic community by enabling researchers understand language dynamic in multicultural settings. Furthermore, the findings may help both doctors and patients in multilingual contexts to better communicate and avoid potential misunderstanding.

Sir, while waiting for a favourable response, I will really appreciate your expediency.

Thanks for your help.

Yours faithfully,

Njweipi-kongor Diana: Applicant
Dr. Bangeni N. J: Supervisor
Prof. Anthonissen C. :Co-Supervisor

Appendix D: Letter to the Provincial Superintendent Western Cape ARV clinics

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

27 January 2009

Dear Sir,

Compliments of the new year to you and the family. Unfortunately we haven't been in touch for such a long time.

I have just received approval from the Department of Health to conduct research at the ARV clinic. I was asked to contact you to help and facilitate arrangements for me to collect data at the clinic. This research is a continuation of the pilot study that Dr. Christine Anthonissen, Dr.Nwabisa Bangeni (both my supervisors) and I did with you in 2005. By then it was part of a larger project that was conducted in the department of General Linguistics but which had since been postponed. However I wish to continue this part of the study to collect data that will contribute towards the completion of my PhD programme in the department of English. I will therefore really appreciate if you speak to the doctors at the Idas Valley clinic on my behalf because they were a little wary of me recording the consultations. Failing this, I won't mind coming to you and Dr. Pasche in the facilities in which you work because you already understand the focus of my research and the need for me to have recorded consultations to work with.

Anxiously waiting to hear from you and thanks in advance.

Best regards.

Njweipi-Kongor Diana B.
Department of English, Faculty of Arts
University of Stellenbosch, Matieland 7602
South Africa
Tel: + 27 82 798 2368 (mobile)
Tel: + 27 21 886 6841 (Home)
email: kongordin@yahoo.com
email: 14683555@sun.ac.za

Fakulteit Lettere en Wysbegeerte - Faculty of Arts
Department Engels - Department of English
Privaatsak/Private Bag X1 • Matieland, 7602 • Suid-Afrika/South Africa
Tel: +27 21 808 2040; Faks/Fax: +27 21 808 3827; E-pos/E-mail: engl@sun.ac.za